ALCOHOL ABUSE AND ITS IMPLICATIONS FOR FAMILIES

HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC., ON
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ALCOHOL ABUSE AND ITS IMPLICATIONS FOR FAMILIES

MONDAY, MARCH 18, 1985

House of Representatives, Prevention Strategies Task Force, Select Committee on Children, Youth, and Families, Jointly With Crisis Intervention Task Force,

Washington, DC.

The Prevention Strategies Task Force of the Select Committee on Children, Youth, and Families and the Crisis Intervention Task Force met jointly, pursuant to call, at 9:40 a.m., in room 2212, Rayburn House Office Building, Hon. George Miller (chairman of the select committee) presiding.

Members present: Representatives Boggs, Lehman, Coats, and Wolf.

Staff present: Alan J. Stone, staff director and counsel; Ann Rosewater, deputy staff director; Marcia Mabee, professional staff; Karabelle Pizzigati, professional staff; Mark Souder, minority staff director; Christopher Reynolds, professional staff; and Joan Godley, committee clerk.

Chairman **Miller**. The Select Committee on Children, Youth, and Families will come to order.

This is a joint hearing between our Task Forces on Prevention Strategies and Crisis Intervention. We hope to take a comprehensive look at the damaging effects of alcoholism on children and families.

I am pleased to recognize the chairman of the Prevention Strategies Task Force, Congressman Lehman of Florida, and then Congresswoman Boggs, chairperson of the Crisis Intervention Task Force.

Mr. **Lehman**. Thank you, Mr. Chairman.

For a matter of expediency I have a statement which I will submit for the record.

[Opening statement referred to follows:]

Opening Statement of Congressman George Miller, a Representative in Congress From the State of California and Chairman, Select Committee on Children, Youth, and Families

The American public is growing more aware, and more concerned, about the damaging effects of alcoholism on children and families.

Our Task Forces on Prevention Strategies and Crisis Intervention have joined together today to take an indepth, comprehensive look at this issue. We need to educate ourselves with regard to the connections between alcohol abuse and many of the most serious family dysfunctions, including family violence, separation and divorce, crime, and suicide.

As is our custom, we will hear from parents and children, researchers, and caregivers. I am especially pleased to welcome Beverly Faria, a parent from Concord, California, in my own county of Contra Costa. It is a testament to her courage that she has come to Washington to offer her experience—her struggle with alcohol, her efforts to continue to be a parent to her children, and her persistence, with the help of the Bi-Bett Corporation's treatment program, to regain a productive life.

It is our hope that, as a result of this hearing, members will have heightened appreciation for the extent and nature of alcohol-related family problems, and a greater sense for how we, working with the private sector and local governments, can do more.

OPENING STATEMENT OF CONGRESSMAN WILLIAM LEHMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA, AND CHAIRMAN, TASK FORCE ON PREVENTION STRATEGIES

I am pleased to be here this morning and to join my chairman, Mr. Miller, Mrs. Boggs, and the members of the Select Committee to examine the issues of alcohol abuse and families—a critical concern for American families across the Nation.

It is fitting that the Prevention Strategies and Crisis Intervention Task Forces jointly begin examination of this important subject. Clearly, strategies for effective intervention, treatment, and prevention must be closely linked to address the complex problems that parents, their children and the family as a whole face when someone in the family is using alcohol to excess.

We have all become more aware of some of the devastating results of alcohol abuse. Best known are the tragedies of drunk driving. It is estimated that drinking and driving claims 25,000 lives each year—some 50 percent of all highway fatalities. Motor vehicle accidents are the most frequent killers of our young people ages 15–24.

Alcohol abuse is related to other serious family problems as well. One of our early Task Force hearings documented the devastating but totally preventable problems of Fetal Alcohol Syndrome—the third leading cause of mental retardation in the nation—that result from drinking during pregnancy. In other Select Committee hearings, witnesses raised the issues of alcohol abuse as a factor in problems of child abuse, adolescent pregnancy, and mental health dysfunction.

National surveys show that alcohol is the first drug of choice among high school students and that children are starting to drink at younger and younger ages. The average age at which young people begin drinking now stands at 13. That is a set-up for difficult sledding, as some of our witnesses, based on their own personal experiences, will tell us today.

I want to welcome and thank all the witnesses for taking the time to be with us today, and to share their work and personal insights concerning the problems of alcohol abuse. I am especially pleased that John Daigle, representing the Florida Governor's Commission on Drug and Alcohol Concerns, could be with us. The Commission has recently issued a report on the problems of substance abuse in the state along with recommendations for action.

I am confident that today's record will help us all to understand better the tremendous toll that alcohol abuse takes on families, as well as how groups and communities around the country are combating the problems.

OPENING STATEMENT OF CONGRESSWOMAN LINDY BOGGS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA, AND CHAIRPERSON, TASK FORCE OF CRISIS INTERVENTION

I want to welcome all of you to the first Crisis Intervention Task Force hearing of the 99th Congress, which is being held jointly with the Prevention Strategies Task Force. Our subject today is "Alcohol and Its Implications for Families." We have chosen to devote our first hearing to this topic because alcohol abuse seemed to be connected to, and to exacerbate, so many problems that American families and their children face.

At our very first crisis intervention task force hearing on "Families in Crisis," we learned that problem drinking increased with unemployment. Problem drinking and unemployment, in turn, caused an increase in spouse abuse, child abuse and in the numbers of teenagers who ran away from home or who were thrown out by parents who could no longer cope. This tragic progression of events was described by a witness from Detroit, Michigan as well as by a witness from Ames, Iowa—the heart of America's farmland.

At our task force hearing on "Teenagers in Crisis," we heard about another tragic consequence of alcohol and drug abuse—teen suicide. Some studies indicate 65% of young people who attempt or succeed in committing suicide are high on alcohol or drugs at the time.

The testimony given at our task force's New Orleans hearing on "Youth and the Justice System," again implicated both parental and teenage abuse of alcohol and drugs in delinquent and criminal behavior.

Today's hearing will take a closer look at how problem drinking is connected to a host of problems facing American families. We will be assisted in this exploration by members of three families who have directly experienced the devastating effects of alcohol and drug abuse. I want to extend a particular welcome to the West family—Mrs. Dot West and her son Bret—who have traveled from Baton Rouge, Louisiana to share with us their very difficult story.

We will also hear from judges, Federal and State administrators, researchers and a private sector parent self-help organization.

I look forward to today's testimony in the expectation that these witnesses, from across the nation, will help us understand the particular problems alcohol abuse poses for families and what can be done to intervene effectively.

Mr. LEHMAN. At this time I would like to recognize the Ranking Representative, Mr. Coats, for a statement.

Mr. COATS. Thank you, Mr. Chairman.

On behalf of Congressman Bliley, who experienced some automobile problems this morning and is on his way, and the other minority members of the committee, I thank the chairman and the Chair of both task forces for holding this hearing. I wish to personally welcome the witnesses here this morning and thank them for their testimony on what I believe to be a very important subject.

There is no doubt that excessive drinking adversely affects the health and social well-being of individual consumers of alcohol, but it is also apparent that alcohol and its effects have an adverse effect on the family as a whole. This is our perspective today.

I also have statements to submit for the record and ask that the testimony of Senator Paula Hawkins of Florida, Virgil Gulker and Ellen Duffy, be submitted for the record and that we keep the record open for 3 days for other members to submit written statements.

Chairman MILLER. Without objection.

[The statements of Paula Hawkins, Virgil Gulker, Ellen Duffy follow:]

PREPARED STATEMENT OF SENATOR PAULA HAWKINS, A SENATOR FROM THE STATE OF FLORIDA

I would like to express my thanks to Chairman Miller and the members of the Select Committee for the opportunity to participate in this hearing today. This invaluable forum provides a unique opportunity to express my concern involving an issue of vital importance.

As chairman of the Senate Subcommittee on Children, Family, Drugs and Alcoholism, and the Senate Drug Enforcement Caucus, I have seen too many examples of the effects of alcohol abuse on the family. It is always the innocent who suffer. The devastating afflictions of alcohol abuse wreak havoc not only on the user, but on the people who love and live with them. The statistics attesting to this are horrifying: the sons of alcoholic fathers are four times more likely to become alcoholics, and the daughters of alcoholic mothers are three times more likely to become alcoholics. This largely silent and neglected group also follows other disturbing patterns: children of alcoholics are often grandchildren of alcoholics, and daughters of alcoholics are more likely to marry alcoholics. They are, as a group, consistently overrepresented in caseloads of medical, psychiatric and child guidance clinics; the criminal and juvenile justice systems; and among victims of child abuse.

Despite all the research that has been done, and the theories that have been proven and disproven, there is still much that we do not know. At one time, it was thought that drinking problems of children of alcoholics were the result of learned behavior; that they learned to drink heavily by observing their parents' behavior. It was also thought that role confusion, resulting from inadequate parental role models, contributed to alcohol problems in the children of alcoholics.

Attitudes have altered greatly since these hypotheses were thought to have basis in fact, and now emphasis is being placed on genetic research to find the solutions to the disease of alcoholism. The result of this most recent train of thought has been largely positive: the necessary attention has been focused on children of alcoholics, and the very special problems they face. Thus, needed encouragement is offered to local, State and Federal agencies, and private organizations, to respond to the unique needs of these children.

In my career as a United States Senator, I have devoted much of my time to the totally unacceptable problem of abuse of children. A particularly heartbreaking statistic painfully indicates that the children of alcoholics, in addition to being more likely to have alcohol-related problems, are also more likely to be victims of child abuse—and in every one of its horrible forms.

This situation must stop. These innocent victims of society must not be allowed to suffer so severely and so unjustly.

There is another aspect of this situation that affects the children of alcoholics as adversely. Often, the nonalcoholic parent can be as big a problem as the alcoholic one. Spouses of alcoholics cannot support their children emotionally because they are so wrapped up in their own survival. Frequently the two parents behave as extreme opposites of each other. Where the alcoholic is unpredictable, the spouse is rigid, for example. So children, where most formidable role models are their parents, don't learn any middle ground behavior, such as flexibility.

There are things we as parents, and as legislators, can do. We can encourage existing programs designed to address the very special needs of these children. For example, programs are currently in operation which teach parents with alcohol abuse problems that by learning more constructive ways of relieving their tension, and by learning better methods of disciplining their children, these parents can address the beginnings, and the results, of child abuse and neglect. Children themselves can learn, or be taught, to get out of the way when they see a pattern of drinking developing that can often lead to abuse.

Another educational process that can be beneficial to preventing certain forms of child abuse and neglect is teaching parents how to manage hyperactive behavior in children, often a reaction to an alcoholic home, at a very early age; this may help these children in preventing socially disruptive behavior that can be problematic in maturity.

It is a fact that crises in an alcoholic home have negative effects on children, often long-lasting, sometimes permanent. It has been determined that frequently sensitivity on the part of officials in the school system to these problems may reverse the negative effects of the alcoholic home. Constructive patterns can be encouraged through counseling, as well as support groups and special course.

Finally, the problem of alcoholism has to be addressed. Children of alcoholics very simply have to take more care than their peers when they consume alcoholic beverages. There is more danger for them if they decide to drink, and they must be made aware of this. They must be made aware of the potentially devastating effects, both physical and psychological, of alcohol, they must, in short, develop an early warning system that can keep the same pattern of abuse and destruction that so affected their own lives.

All these efforts are, indeed, specialized, and directed at a very special group, but it is a group that has been neglected for too long. In our mutual efforts to create a better world for our children, we must ensure that their freedom to develop and grow, from fetus to maturity, is not destroyed because of the disease of alcoholism.

Thank you again, Chairman Miller, Congressman Coats, and every member of the House Select Committee on Children, Youth, and the Family. I commend you all for your untiring efforts in behalf of the youth of our nation, and wish to assure you that I join you in the Congressional effort to provide protection for our children.

PREPARED STATEMENT OF VIRGIL GULKER, D.A., FOUNDER AND PRESIDENT, LOVE INC., CHURCH SERVICES NETWORKS

Thank you, Members of Select Committee on Children, Youth, and Families, for the opportunity to share this statement on behalf of LOVE Inc. Church Services Networks on the subject of alcohol abuse and its implications for the family. Let me also express my sincere appreciation to the Select Committee for addressing the pressing needs of the alcoholic's forgotten family, the spouses and children who live each day with pain, fear and shame.

I am Dr. Virgil Gulker, Founder and President LOVE Inc. Church Services Networks in Holland, Michigan. LOVE Inc. Community clearinghouse programs in seven states have organized churches from over forty denominations to work cooperatively with agencies in meeting individual and family needs. As of December 1984, LOVE Inc. was active or developing in approximately 400 communities (towns and counties) across America ranging in size from eight churches to over 150 churches. These programs have harnessed largely untapped volunteer and material resources to meet physical, emotional, spiritual and mental needs. In 1984, LOVE Inc. received 179 requests for information on their services from 27 states. Since 1981, we have received requests from 42 states and 6 countries.

This statement will share information about the experience of these programs in addressing family needs.

FAMILY NEEDS

It is no longer difficult to catalog the symptoms of the troubled American family. We have only to look within our own communities, our own neighborhoods, and, in many cases, even our own homes to witness the steady disintegration of this basic social unit.

The multiple causes for our troubled families often seem as complex and varied as the symptoms themselves. Two separate but interrelated factors emerge, however, as we examine the families involved with helping service systems.

The first factor, or benefit, is the long-term availability of a program or subsidy which supplants the family's primary role as provider. External and artifical support systems undermine the reliance of interdependent family members on each other and themselves for their own needs. The dependence which results from this process generally diminishes the value of the traditional family unit and strips the individual of the incentive to provide for his family.

The second factor is created by the failure or inability of one or more family members, especially parents, to assume responsibility for his or her own actions. This factor describes the relationship between an alcoholic and his beleaguered family and is often the stimulus for many other family problems, including marital violence.

Arnold W., a recovering alcoholic and a LOVE Inc. Program Director in a midwestern community, shares these pained reflections about the nature of that relationship:

"My family was under constant strain and pressure. As the disease progressed, they became as emotionally, spiritually and even physically ill as I was. The only difference was that they did not drink. My family was plagued with financial and legal problems, marital problems and the emotional abuse and neglect of our children. They felt fear, desperation and a sense that there was no way out of their situation, no relief from the devastation created by alcoholism. As the family situation and the disease worsened, my spouse and children shouldered the total responsibility for the family and all their problems."

Public and private helping services are available within most communities for the families of alcoholics. Unfortunately, these services often contribute to the problem by treating symptoms instead of causes. By providing for the physiological needs of the alcoholic and his family, agencies supplant the responsibility of the alcoholic and his family to provide for their own needs. In this manner, the alcoholic is inadvertently allowed to continue drinking.

The provision of food, clothing, housing and other basic services also misses the mark for another reason: most of these families need far more than a bag of groceries, a safe bed or a warm coat; they desperately need to interact with people who will affirm their value. Arnold W.'s wife, Glenda, recounts her desperate need years earlier for someone to love her when the "pain was so intense that it overwhelmed my religious faith, my love for my children and even my will to live."

CHURCH INVOLVEMENT

Several things can be said about the idea of helping service resources in most communities to meet increasing family needs: most helping services are duplicated unnecessarily; agencies and churches generally help the same people on a regular basis; funding cuts are seriously limiting agency services; church volunteer and material resources are neither organized nor used; and, there is not comprehensive policy for the provision of basic services.

LOVE Inc. Community Clearinghouses equip communities to use their resources more effectively by organizing churches to work cooperatively with helping agencies in meeting individual and family needs. As a liaison between needy individuals, agencies and churches, the clearinghouse reduces the unnecessary duplication of services. It also identifies and teaches self-help skills to chronic dependents and generates previously untapped church resources.

The incredible range of volunteer services available within a particular church becomes obvious when you ask members of that church to develop and inventory of their interests and talents. You will find teachers, counselors, administrators, budget planners, successful parents and grandparents, companions, plumbers, carpenters and electricians. You may also find professionals, doctors, nurses, lawyers and other—who are willing to respond to needs as part of the ministry of their churches.

LOVE Inc. churches respond to a wide variety of basic needs in communities where those services are not available. In other communities, churches have been equipped to sponsor service projects, many of which are offered at tax expense elsewhere. For example, twenty four churches in one city operate a shelter care home for abused women and their children.

LOVE Inc. also develops contractual helping relationships between church volunteers and high-risk client families. Under the terms of this contract, church members do far more than merely minister to a client's immediate physical need; they are active participants *with* the client in a personalized helping experience designed to affirm the individual, strengthen the family, encourage personal responsibility and teach basic lessons in living. The result is change and hope for people caught in the clutches or poverty, abuse, loneliness and despair.

The interaction between church volunteer and client family has special value because it is more than a sterile helping transaction. Unlike public agency employees, church volunteers are not saddled by unmanageable caseloads, nor are they obliged to process needs routinely in the impersonal manner prescribed by law or departmental regulation. Church volunteers provide personalized assistance for people who live in their own neighborhoods. They can take the time to know and understand the family members and they can fashion caring relationships to help these individuals rediscover their dignity and self-esteem. In this way LOVE Inc. provides a means for families to be involved in helping families.

Thank you for the opportunity to share this statement on behalf of Love Inc. Church Service Networks.

PREPARED STATEMENT OF ELLEN DUFFY, CPC COORDINATOR, ALCOHOL ABUSE AND ITS EFFECTS ON THE FAMILY, AL-ANON FAMILY GROUP HEADQUARTERS, INC.

Esteemed members of the House of Representatives, we thank you for requesting testimony from members of the Al-Anon Family Groups on behalf of families of alcoholics worldwide. In the past few years professionals in the field of alcoholism have come to recognize the needs of the family. How encouraging it is to see the House of Representatives join in this awareness. The Al-Anon fellowship, a pioneer in the self-help movement, has based its program on the now accepted premise that alcoholism is a family disease and that families of alcoholics need help whether the alcoholic seeks help or even recognizes the existence of a drinking problem.

The following testimony outlines the effects of alcoholism on the family, provides an overview of the Al-Anon structure and a description of the Al-Anon/Alateen program of recovery.

THE EFFECTS OF ALCOHOLISM ON THE FAMILY

Alcoholism is a family disease. Compulsive drinking affects the drinker and it affects the drinker's relationships; friendships, employment, childhood, parenthood, love affairs, marriages, all suffer from the effects of alcoholism. Those special relationships in which a person is really close to an alcoholic are affected most, and the people who care are the most caught up in the behavior of another person. They react to an alcoholic's behavior. They see that the drinking is out of hand and they try to control it. They are ashamed of the public scenes but in private they try to control it. It isn't long before they feel they are to blame and take on the hurts, the fears, the guilt of an alcoholic. They become sick, too.

These well-meaning people begin to count the number of drinks another person is having. They pour expensive liquor down drains, search the house for hidden bottles, listen for the sounds of opening cans. All their thinking is directed at what the alcoholic is doing and how to get him/her to stop drinking. This is their obsession.

Watching other human beings slowly kill themselves with alcohol is painful. While the alcoholic doesn't seem to be worrying about the bills, the job, the children, the condition of his/her health, people around begin to worry. They make the mistake of covering up. They fix everything, make excuses, tell little lies to mend damaged relationships, and they worry some more. This is their anxiety.

Sooner or later the alcoholic's behavior makes those around him angry. They realize that the alcoholic is not taking care of responsibilities, is telling lies, using them. They have begun to feel that the alcoholic doesn't love them and they want to strike back, punish, make the alcoholic pay for the hurt and frustration caused by uncontrolled drinking. This is their anger.

Those who are close to the alcoholic begin to pretend. They accept promises, they believe, they want to believe the problem has gone away each time there is a sober period. When every good sense tells them there is something wrong with the alcoholic's drinking and thinking, they still hide how they feel and what they know. This is their denial.

Perhaps the most severe damage to those who have shared some part of life with an alcoholic comes in the form of the nagging belief that they are somehow at fault, they were not up to it all, not attractive enough, not clever enough to have solved this problem for the one they love. They think it was something they did or did not do. These are their feelings of guilt. [from the pamphlet "Understanding Ourselves and Alcoholism" copyright Al-Anon Family Group Headquarters, Inc.]

The children of alcoholics are affected in many ways. They are sometimes hurt directly by the alcoholic's behavior, especially if there is violence. While he is drinking, the alcoholic often makes promises he can't keep or doesn't remember making. Children may be ashamed of their home or afraid they will be embarrassed in front of their friends. They may even blame themselves for the alcoholic's drinking.

The nonalcoholic parent may give the children problems too. As a result of their preoccupation with the drinking problem, they are often irritable, inconsistent, demanding and frequently neglect the children. They may try to get the child to help control the alcoholic by watching him, keeping quiet so as not to disturb him, going to the bar to get him, telling lies to hide the problem from the neighbors. They may even blame the child for the drinking.

It is no wonder then, that these youngsters end up hating themselves, their parents, their lives, and everything in it. They may have trouble with school work, be afraid of people, lack self-confidence, fear the future, or suffer from "nervous" disorders. Some run away from home or get into trouble with the law. (From "Alateen—Hope for Children of Alcoholics" copyright Al-Anon Family Group Headquarters, Inc.)

Family members believe it's easier not to talk, trust or feel and they learn ways of coping that prove inappropriate. This causes many to feel confusion, a false sense of self, and a great sense of despair. Many feel victimized, abandoned and alone.

AN OVERVIEW OF THE AL-ANON STRUCTURE

Al-Anon is a worldwide organization with a self-help recovery program for the families and friends of alcoholics. Members give and receive comfort and understanding through mutual exchange of experiences, strength and hope. Sharing of similar problems binds individuals and groups together in a bond that is protected by a policy of anonymity. There are no dues or fees. Al-Anon is self-supporting through members voluntary contributions. (Contributions from outside agenices and individuals are gratefully acknowledged and returned.) Al-Anon groups hold meetings regularly, usually on a weekly basis. Membership is voluntary, requiring only that one's own life has been adversely affected by someone else's drinking problem.

Alateen, for teenage members, is a part of Al-Anon. It operates within the same set of principles. Alateen meetings are conducted by the teenagers themselves and guided by an Al-Anon member.

Al-Anon is not a religious organization nor a counseling agency. It is not a treatment center nor is it allied with any other organization. Al-Anon Family Groups neither express opinions on outside issues nor endorses outside enterprises. Al-Anon does, however, cooperate with those in the fields of law, education, medicine, religion, industry and government.

Contrary to popular misconception, Alateen is not for teenage alcoholics. Although members of Al-Anon or Alateen may also personally suffer from alcoholism, they frequently come to Al-Anon and Alateen to find help from the effects of another's alcoholism.

A DESCRIPTION OF THE AL-ANON PROGRAM OF RECOVERY

Al-Anon works because it is a positive program that is grounded in the common experiences of its members—people whose lives are or have been affected by someone else's drinking. It works because it helps members focus on themselves and their own recovery. Above all, Al-Anon works because it is a simple program. Its simplicity lies in experience shared at meetings. When a member shares depair, problems of abuse, violence, financial deprivation at a meeting, invariably a member will respond. "I've had a similar experience and here's how I handled it." This sharing allows the newcomer to leave the meeting with hope, a feeling of belonging and a belief there is a solution.

Al-Anon's simplicity is further reflected in the following tools of the program.

Utilizing The Twelve Steps and Twelve Traditions of Alcoholics Anonymous (see literature enclosed).

Attending Al-Anon and Alateen meetings on a regular basis.

Reading Al-Anon literature.

Making telephone contact with members.

Practicing the principles embodied in the Al-Anon program such as the use of positive slogans and the Serenity Prayer.

Al-Anon helps members understand alcoholism is a family disease, and living with the effects of someone else's drinking is too devastating for most people to bear without help. They learn they are not responsible for another person's disease or recovery from it and that letting go of their obsession with another's behavior leads to happier, more manageable lives. Al-Anon helps families look at their situation realistically and objectively, thereby making intelligent choices possible, so that the chain of destructive effects of alcoholism on the family in one generation after another can be broken.

An example taken from a letter which appeared in Al-Anon's monthly magazine "The Forum" describes the generational chain of alcoholism:

"On the memorable day I walked into my first Al-Anon meeting, I was into my fourth alcoholic relationship.

"I was born into relationship #1 as my father is an alcoholic. Being brought up in an alcoholic home set the pattern for my later choice of marriage partners.

"Relationship #2 began when I married a man 3 months after I met him because I wanted to get away from home. After 2 years and two children, the marriage ended. A year later, I became involved in another relationship that lasted 10 years. The last few years were violent and my children suffered from all the turmoil. When this association ended, I was emotionally unstable and I put my children through hell all by myself.

"One evening I met a man who was visiting my hometown from another state. That began relationship #4. This marriage was also a disaster.

"Finally, my Higher Power stepped in an guided me to Al-Anon. Thanks to Al-Anon, I not only have found myself, but I have found my children. I have made my amends to them and we have an understanding I never dreamed possible."

Perhaps the best illustration of the help found in Al-Anon is reflected in the personal stories of our members. One story taken from the pamphlet "Al-Anon Sharing From Adult Children" states:

"My mother phones, her voice soft and motherly. She tells me what she's doing, how grandmother is getting through the winter and about the sweater she's knitting. She sounds like a typical mother, so loving, and pouring affection through the wires from long-distance.

"She calls me again, not the mother I have talked to earlier, another mother, screaming obscenities, voicing disappointment in her only daughter. She's drunk. The hurt goes deeper than tears could express. I feel a sense of inferiority, inadequancy, quilt, frustration.

"Dad calls. He tells me that she is drunk again, drunk and viciously mean. He says the house is a mess, he's depressed, seriously depressed. A binge drinker, he will be drunk before the night is over. He will use her behavior as his excuse.

"I stand for a minute with my hand on the phone, reflecting on the tragedy of their mutual disease of alcoholism, the waste of their lives, the days and nights spend in self-destructive drinking. I regret the loving they are not able to give me, but these thoughts are soon replaced.

"Today I have Al-Anon. Today there are my responsibilities to meet, bills to be paid, apppointments to be kept, painful and pleasant decisions to be made. At Al-Anon meetings, I have learned how to live through and with the hurts and resentments that have been part of my childhood and my adult life. I know it is possible for me to accept my parent's illness and preserve my own sanity. I can make the daily effort, refusing to be martyr, refusing to feel sorry for myself or my children. I needn't hide behind the pressures of this illness, a convenient wall that once allowed me to excuse my own failures. The challenges in living are continually part of my life whether my parents are drunk or sober.

I live this day today."

Other stories sharing the effects of alcoholism on the family and their recovery in Al-Anon may be found in the enclosed Al-Anon pamphlets "Alcoholism, The Family Disease," "To The Mother and Father of An Alcoholic" and "Al-Anon Sharings From Adult Children."

Possibly the best illustration of Al-Anon's success is reflected in its growth. Al-Anon began in 1951 with 50 groups. Today there are over 26,000 Al-Anon and Alateen groups in almost 90 countries throughout the world. Recent figures show approximately 19,000 Al-Anon and Alateen groups in the U.S., 2,400 in Canada and 5,500 in other countries.

Al-Anon Family Group Headquarters, Inc. welcomes the continued opportunity to cooperate with your esteemed body to provide any other information in order to help us in our mission to reach out to families of alcoholics everywhere.

Chairman **Miller**. Mr. Lehman.

Mr. **Lehman**. At this time, Mr. Chairman, I would like to recognize the chairman of the Task Force on Crisis Intervention, Mrs. Boggs, and I would be happy to yield to Mrs. Boggs.

Mrs. **Boggs**. Thank you so much, Mr. Chairman, and Mr. Big Chairman.

I want to welcome all of you to this first Crisis Intervention Task Force hearing of the 99th Congress which of course is being held jointly with the Prevention Strategies Task Force.

Our subject today, alcohol and its implications for families, was chosen because alcohol abuse seemed to be connected to, and to exacerbate so many problems that American families and their children face.

At our very first crisis intervention task force hearing on families in crisis, we learned that problem drinking increased with unemployment. Problem drinking and unemployment in turn caused an increase in spouse abuse, child abuse and in the numbers of teenagers who ran away from home or the so-called throwaway children who were thrown out by parents who could no longer cope. This tragic progression of events was described by a witness from Detroit, MI, as well as by a witness from Ames, IA, the heart of America's farmland.

At our task force hearing on teenagers in crisis, we heard about another tragic consequence of alcohol and drug abuse, teen suicide. Some studies indicate 65 percent of young people who attempt or succeed in committing suicide are high on alcohol or drugs at the time.

The testimony given at our task force's New Orleans hearing on youth and the justice system again implicated both parental and teenage abuse of alcohol and drugs in delinquent or criminal behavior.

Today's hearing will take a closer look at how problem drinking is connected to a host of problems facing American families. We will be assisted in this exploration by members of three families who have directly experienced the devasting effects of alcohol and drug abuse.

I want to extend a particular welcome to one family Dot West and her son, Bret, who traveled from my home State of Louisiana to share with us their very difficult story.

We will also hear from judges, Federal and State administrators, researchers, and a private sector parent self-help organization.

I look forward to today's testimony in the expectation that these witnesess, from across the Nation, will help us understand the particular problems alcohol abuse poses for families and what can be done to intervene effectively.

Thank you, Mr. Chairman.

Chairman MILLER. Thank you, and thank you for all of the help that you and Mr. Lehman have provided in putting this hearing together.

We will hear now from our first panel. I would like to personally welcome one of our witnesses, Beverly Faria, who came here from my district to provide us her testimony and to help us better understand this problem.

We want to welcome the other witness, Marjorie, a parent in Montgomery County, MD; Dot West, Bret West, if those panelists will come forward to the witness table.

Welcome to the committee. We are delighted to have you. Sit down in any order you wish. Make yourselves comfortable. We appreciate your taking the time and making this effort to help us. We want you to feel comfortable, and to proceed in the manner in which you are most comfortable.

You can read your statements, but they will be included in the record as written. If you want to summarize them, that is also fine. Proceed however you wish. We will hear first from Dot West.

STATEMENT OF DOT WEST, PARENT, BATON ROUGE, LA

Mrs. WEST. Good morning.

Chairman MILLER. First thing you will have to do is pull that microphone up because we have a room full of people who want to hear what you have to say.

Mrs. WEST. I am Dot West, the daughter of an alcoholic and mother of three alcoholic sons, Chris, Bret, and Joel.

Since both my husband and I had been raised in homes with alcoholic behavior we brought that behavior with us and when we became aware that our boys were abusing drugs this behavior became more intensified.

I want to describe to you this morning what happened in my family when my boys became involved in drugs. The first stage I call the awareness stage because this is when I began to notice a change in all three of the boys' behavior.

My oldest son was in the ninth grade and they quit playing football, taking part in band, or swimming on the swimming teams, and choir, and instead they started hanging out with their friends and isolating themselves in their rooms to listen to rock music.

At the time their grades began to get bad. They were disrespectful, belligerent, they didn't want to have anything to do with us, didn't want to go on trips with us, go to church with us, and in fact, I think it would have taken a congressional amendment to get them to take out the garbage.

I was really alarmed and I started talking to some of their friends' parents to see if they saw this behavior, and they were. We all agreed that it was adolescent. I could accept this because somewhere in the back of my mind I had the suspicion that it might be drugs, but I didn't want to admit this. In fact, I couldn't because I had two of my sons who were in the gifted and talented program and I was sure that they were far too intelligent to do anything so dumb as do drugs.

It wasn't until my oldest son came on the campus in the 10th grade to the school where I teach, that I noticed the friends he was hanging around with and I knew that he was into drugs. A few months later he got caught on the campus for pushing drugs and my husband and I just panicked.

I call this next stage the police state and the KGB because that is exactly what it is like. My husband put a bug on the phone so he could keep up with what was going on with the boys. We started searching their rooms down, my husband asked some of his State police friends to come out and talk to the boys and use scare tactics on them.

We asked the minister to talk to them and any meaningful person in their life who we thought would have an influence on them.

At the time we started a series of counseling sessions that lasted until the time that we finally put them in the adolescent unit at the CDU. I did my crazy thing, I made them ride to school with me and stand by me on duty. I constantly checked with their teachers to be sure they were in the classroom. I asked for running reports on their grades and I did investigations on any person that I saw them hanging with.

We took all their privileges away from them. We wrote enough house rules we could have published a book from it. All this time we were trying to manipulate and control their behavior and also to manipulate and control the environment they were in, they were doing some of their own manipulating.

This is the letter I got from Bret at the time:

> A couple of weeks ago you gave us privileges so long as we were straightened up. In the past couple of weeks I have been straighter than I have been in two years. We used to buy pot as soon as we got money, now we smoke a joint occasionally, on weekends, not during school. We have taken up more wholesome activities and have a better understanding about life. Now you plan to take every privilege and right we have.
>
> We were straightening out so we could do something for you all as well as us. In return you were making our life a little easier. If you take every right we have it is going to be that much harder for us to do something for you. This is true because I know it and I know how we think. I don't mean for this letter to be any form of blackmail because it isn't. I just wish you would think about this letter very carefully. Love always, Bret. P.S., I am the same old Bret with only one difference, smoking pot.

So I called the next stage the prosecutor and giant enabler because nothing we were doing was helping, so my husband began a lecture series and he began every one of those lectures with, "When I was your age," and the truth is we were never their age.

We didn't grow up in an environment where alcohol and drugs were acceptable. And we were not brainwashed by television set from early age telling us to take a pill, to make us feel better, or to drink this certain drink that fit in with this certain group.

My boys had received that message well and what it said to them is that a chemical can solve all your problems so their father's lectures on responsibility for oneself were never heard.

He began his get tough policy and he was meting out some pretty stiff sentences. That was fine except he chose me to be sure that they were carried out, so in order to save myself and the boys, I quit reporting on any of their activities.

If they were in trouble with speeding tickets, fighting at school, whatever, I ceased reporting it and I became one of their giant enablers. Along with me, I had a maid who had been with the family for 15 years, and she ceased reporting liquor bottles, beer cans, drug paraphernalia, anything she found while she was cleaning up and while this was all going on the marriage was dissipating.

The next stage I call the dissolution of marriage and social life. During this time, my husband and I ceased taking vacations together or going anyplace together because we couldn't trust the boys to stay home with the babysitter and we couldn't ask the grandparents to babysit with them any more because we were into protecting them to keep them from knowing what was going on in the home.

We were also blaming each other for what was going on. We were constantly arguing as to which course to pursue next. My husband, not being the doormat that I was, wanted to tell them to shape up or ship out. I couldn't put them on the street so we began living with the problem.

The next stage I call the living death. We had exhausted just about every avenue of help that we knew about and so our life had become just pretty devastated at this point. The boys' vocabulary consisted of all four-letter words. Their reading material was the High Times magazine which taught them how to cultivate their own marijuana and make their homemade bongs and pipes.

Their father, who had taken them to Indian guides and camped out with them, now was pushing them against the walls and screaming at them. And they were responding with their fists. Instead of baking cookies with me or making homemade valentines, they were drying pot out in the attic and drawing pictures of their rock singers who had died from drug abuse and mimicking those new heros' behavior.

Instead of refereeing their sibling arguments I was beginning to witness the boys beating each other up over their drugs and the holocaust was complete. By this time every facet of my life was controlled by my chemical, Chris, Bret, and Joel, and every area of their life was controlled by their chemical, alcohol and drugs.

My husband was threatening to leave the household. I was no longer going to the teacher's lounge to drink coffee or with my neighborhood friends because I had this big secret that everybody knew about but nobody could talk about.

I no longer corresponded with my brothers or went by to visit my mother. I had ceased going to church. I thought God was punishing me for the sins of my father. I had completely isolated myself and from any support system I was isolated.

The next stage I call the CDU and the new life. It was in the 1980–81 school year that my faculty decided to do a study on drug abuse in the schools and the CDU center counselor and four recovering students who had gone through their adolescent unit out to talk to our faculty.

As those four students began talking to us about what their lives were like when they were junkies I was squirming and I could hardly sit there. Finally, when the meeting was over the counselor passed out some cards to us and she told us if we needed her to contact us to write our telephone number on the cards.

I was so nervous that I couldn't even write my name on the card and I ran out of that meeting and went home and I called my husband and I said, Don, mortgage the house because we are going to put these three kids in treatment. And that is what we did. I think it is the best thing we ever did in our whole life.

Until our family went through the adolescent unit at the CDU, I had no idea what normal behavior was either for myself or for the children and when the boys returned from their respective halfway houses around Christmas time we functioned as a normal family for the first time in my life.

We were able to share feelings. I was able to say, "I love you," and to hear my children say, "I love you," without being embarrassed. And they wanted to spend time with us and they wanted to eat meals with us and I remember the first meal that we ate together when they got back, my oldest son asked to say the blessing which consisted of one line, "Thank you, God, for choosing our family to get well."

And I cried because after generations of alcoholism in our family on both sides of our family, we had been able to intervene, and our boys were not going to have to suffer and live those lives of desperation that I had seen in my own home.

We now had a chance to be all that we could be and it has been 4 years now since our boys went through the adolescent unit and I think that we have had a really good recovery.

I am beginning to receive homemade valentines again. This is one I got this year from Bret. It says:

> Thank you for the support and love you have given me through the years. I want you to know that I appreciate it though sometimes I don't always show it. I don't show it as often as I should, but I love you.—Bret.

Thank you.

Chairman MILLER. Thank you very much.

[Prepared statement of Dot West follows:]

PREPARED STATEMENT OF DOT WEST

INTRODUCTION

I'm Dot West, the daughter of an alcoholic and the mother of three alcoholic sons, Chris, Bret, and Joel. Since both my husband and I had been raised in homes with alcoholic behavior, we brought those behaviors into the marriage. That crazy behavior was intensified when drug abuse became evident in our own home. I am going to describe to you the stages of development that drug abuse followed in destroying our family.

AWARENESS

I began to notice the change in the boys behavior when the oldest son was in the ninth grade. They started quiting activities such as football, swimming, band, and choir and replacing that time by hanging out with friends. Their grades shifted downward. I was catching them in lies, missing money and other valuables, and they no longer wanted to take part in family activities. It took an act of Congress to get them to do simple jobs around the house. They became disrespectful and belligerent. I grew alarmed. I checked with their friends' parents to see if they were seeing this type of behavior with their children. We all agreed that it was adolescent behavior. It wasn't until my oldest son entered the 10th grade at the high school where I teach that I realized that he was involved in drugs. I saw the junkie kids he was hanging around, and I had this gut feeling that something serious was wrong. Not long after he came on campus, he was caught pushing. I call the next stage . . .

THE POLICE STATE AND THE KGB

We panicked. We tried to control and manipulate their behavior. My husband put a bug on the telephone. He asked some of his state police friends to use scare tactics on them. We had ministers and meaningful persons in their lives to talk to them. We entered the first of a long series of counseling sessions. We continuously searched their rooms. I made them ride to and from school with me and to stand by me on duty after they finished eating their lunch. I constantly checked with their teachers to be sure they were in class. I asked the teachers for a running report on their grades. I investigated all of their friends and watched them to see with whom they were associating. We took all privileges away from them and established so many house rules that we could have published a book from them. While we were into this behavior, they were into some of their own manipulating. (Read Bret's letter) I call the next stage . . .

PROSECUTOR AND GIANT ENABLERS

Since nothing we were doing seemed to improve the problems in the family, my husband initiated his lecture series which were designed to place guilt and shame upon the boys' conscience. They all opened with "When I was growing up . . ." and the subjects covered everything from morality to attitudes and responsibilities. His "get tough" policy metted out some pretty stiff sentences, and I was appointed to carry them out; thus I became their enabler. In order to protect both myself and the boys from him, I neglected to tell him about the trouble they were into such as speeding tickets, fights at school, and disrespect to their teachers. My maid, who had been with the family for 15 years, ceased reporting the liquor bottles, beer cans, marijuana, pills, papers, and pipes that she was finding. While all of this was going on, the marriage dissipated.

DISSOLUTION OF MARRIAGE AND SOCIAL LIFE

We could no longer trust the boys to behave so we couldn't call on the grandparents, who did not know what was going on, to babysit while we took trips, attended conventions, went to out of state ball games so we took separate banquet or business meetings. By this time we were into blaming each other and into disagreeing on what course of action to pursue. My husband was not the doormat that I was, and he wanted to issue the ultimatum of either shaping up or getting out. I call the next stage . . .

THE LIVING DEATH

We had exhausted all avenues of help that we knew were available without any positive results so we began living with the problem. What was our life like? Each of us were shut up in our own separate boxes trying to cope while our whole world was being blown apart by chemicals. The boys had developed their vocabulary into all four letter words. Their new reading material consisted of THE HIGH TIMES magazine which taught them how to cultivate their own marijuana and how to make their own home made pipes and bongs. Their father who had gone to Indian Guides with them and camped with them was now knocking them up against the walls and screaming at them, and they were responding with their fists. Instead of helping me bake cookies and making me home made valentines, they were drying pot out in the attic and drawing pictures of their favorite rock singers, who had died from drug abuse, and they were mimicking the behavior of their new heroes. Instead of refereeing their petty sibling arguments, I was witnessing brothers beating each other up over drugs. The holocaust was complete. The next stage was . . .

PROGRESSION OF THE ILLNESS

By this time every facet of my life was completely controlled by my chemical, my children, just as all areas of their lives were controlled by their chemical, drugs and alcohol. My husband had all he could take and was threatening to leave the household. I quit going to the teacher's lounge or drinking coffee with neighborhood friends because I had the big secret that everybody knew about but nobody could talk about. I no longer corresponded with my brothers. I limited my visits with my mother. I no longer attended church because I was angry with God for punishing me for "the sins of my father." I had isolated myself from any kind of support system. I felt the guilt and shame of a wife, a mother, and a daughter who had failed. The next stage I call . . .

THE CDU AND A NEW LIFE

During the 1980–81 school year, our faculty did a faculty study on drug abuse and a counselor from the CDU along with four recovering students who had gone through the ACDU talked to our faculty. The students' talks about their lives as junkies was so much like the lives of my boys that I could hardly sit through the meeting. At the end of the meeting, the counselor handed out cards for the teachers to write their names and phone numbers on if we needed her to contact us. My hand was shaking so bad that I couldn't write. I left the meeting, went home, called my husband, and told him to mortgage the house because we were going to put the boys in treatment.

RECOVERY

Until our family went through the unit, I had no idea what was "normal" for either their behavior or mine. The boys returned home from their respective halfway houses at Christmas and we functioned as a normal family for the first time in my entire life. We were able to share feelings with each other. I could say I love you and hear them tell me, "I love you, Mom," without feeling embarrassed. I was amazed that they wanted to spend time with us and that they would actually eat family meals with us. I remember the first meal that we ate together after they all got home. My oldest son asked to say the blessing which consisted of one sentence. "Thank you, God, for choosing our family to get well." I cried. Finally, after many generations of alcoholism on both sides of the family, we had been able to intervene to keep history from repeating itself. Our boys will not have to live lives of desperation. Today, we are nearly four years into recovery, and we have the opportunity to be the best we can be. Oh yes, I'm beginning to receive home made valentines again. (Read Bret's 1985 Valentine.)

FOOTNOTE

I have never wanted to tell my story before because the recall is too painful, but when the CDU called and asked me if I would talk to you today, I came—not for my family—because we are addressing our problems but because as a teacher I'm scared. For the past four years I've been working on the alcohol and drug prevention team that contacts parents when we feel that their children may be harmfully involved in drugs. In spite of the increased efforts of our school board and community, I see the problem escalating, and I think the scope of the problem is too large to be taken care of locally. I see our state spending millions of dollars a year to improve the teaching ability of its teachers, but this is to no avail when the students are not in the condition to learn. I think the problems in discipline and low ACT scores are indicative of the increased chemical use among our youth. I no longer scoff at Huxley's BRAVE NEW WORLD, a novel that depicts a society in which the materialistic god Ford controls the whole world by chemicals. I'm terrified because I'm seeing his prediction come true. I don't know what to do; may be you do.

Chairman **MILLER**. Bret, did you want to say something at this time?

STATEMENT OF BRET WEST

Mr. **BRET WEST**. Yes, I would.

I am Bret West, a recovering alcoholic and drug addict and I guess the one thing I would like to say is I am not an expert on alcoholism by any means. A little less than 4 years ago a miracle happened to me, I stopped drinking and the years that have preceded that, probably 6 years, were probably some of the loneliest, craziest and I guess the most desperate times in my life.

I am very grateful to be here today. But for the grace of God, my family and a whole lot of special people I sit here today alive and sober.

I guess my parents are what I call your average parents, church going, didn't fight, very supportive and above all, didn't drink. My friends were plentiful and life was very normal for me. Being the middle son of three sons I guess I tended to get a little less attention than my older brother, who had had a learning disability, and my younger brother, who constantly acted out, and somewhere along the line I learned that I could get attention by making good grades and participating in good old sports, you know.

I soon became the family hero, the spitting image of the American kid, the good grades, popular, the sports, all the way down to the red hair and freckles. Life was very pleasant and carefree, you know, who could ask for more, really?

As I reached the age of 12, my life began to change. I entered into junior high and for the first time I became interested in girls and I was also for the first time associated with drugs and alcohol and people who drank and people who did drugs.

I guess as I entered adolescence I began to take a little closer look at myself and all the insecurities of puberty were definitely setting in. I began to—became more unwanting of my red hair and freckles and I was very scared of girls and I don't know, it's like for me I had so many questions and so few answers.

I was just afraid of consulting my parents, basically I got a lot of my own sexuality and everything from overheard conversations of my peers.

But I will never forget the night of my first drink. Like I said, it was the summer of seventh grade, and I was invited to a party by my friends down the street. I sat petrified on the couch and I felt real withdrawn, like I was on the outside of this party looking in, like everybody else was having fun and I was just kind of sitting there. I was really scared. I felt unloved, and unwanted, ugly, all these negative feelings, I had so many feelings.

About the middle of the evening I was like, I don't want to be here, why did I come. I didn't understand it. Me and a couple buddies went out and picked up the beer we had stashed earlier that afternoon. I knew when I bought the beer that it was wrong, I knew that. But a lot of it was peer pressure. It was the cool thing to do.

I really didn't like the taste of alcohol and I guess it probably would have been a little better if it was cold, being it had been in the ditch all afternoon. But I noticed when I went back to that party, even though I didn't like alcohol I managed to get down about four or five Miller ponies and I noticed there was a definite change when I walked back into that party, because I walked back in and my head was held high, you now, I was good looking, charming, you know, life of the party, you know, what would you do without me now?

I was talking to girls, very, very easily, you know, and you know, everything about it, you know, everything about alcohol made me, everything—made me everything I thought I could be but more important it made me forget my problems.

I went home that evening thinking that I had found the answer to all my dreams and only to find out 4 or 5 years later that it was just my living nightmare.

Already an alcohol pattern started to develop as the next few weekends were to consist of, I guess, obtaining that euphoria that I felt that first night. I began to become really disinterested in my family and any family activities and within the next year I dropped all my outside activities, sports, and everything.

Getting drunk was already my No. 1 priority, as my grades began to lower, there was real evidence of that, you know. As I reached ninth grade I had my first joint of marijuana, the one thing I swore I would never do, drugs. The trilogy was well at hand as my life began to decaying morally, physically, and spiritually. The pride I had once for my father had all but diminished, my mother had become a nag and I the rebel.

I couldn't understand my parent's need to govern my life. My life was so free, you know, so—communication came to a standstill, all our conversations consisted of was nothing but arguments and series of questions and accusations, where are you going, where you been, you smell like booze. That is all the conversations we had ever consisted of.

I can remember sitting upstairs and laying down on my bed and listening to my parents arguing with my older brother who was also an addict, listen to them fight and look up at the ceiling, kind of, and wondering, you know, what had gone wrong? Why did my life seem so crazy? I can't understand it.

My use of drugs began to progress. At 16 I was taking stimulants, downers, hallucinogenic mushrooms, a far cry from the all American kid, you know, getting high became my No. 1 priority even though my grades maintained a good average and I maintained a part-time job, my grades were nothing for me but a way of getting my parents off my back, and I realized that a long time ago.

The job was nothing, my job made me look good but it also supported my habits. My homelife consisted basically of room and board. I came in—left in the morning, went to school, got high, you know, got high at work, whatever, came in and ate, went out, drank, came back in and slept. That is all it consisted of.

My blood was beginning to run cold as my other association with my brothers was nothing more than to use them for their drugs and alcohol. It's like I remember back then even using my own flesh and blood, you know, for nothing more than a high. I remember the struggle of emotions within me, but I was no longer in control of my life. I was very out of control and I couldn't help it. I really couldn't help myself.

By the time I reached my senior year I wanted out of my dilemma. I really did. Being called a head was no longer a compliment for me. So I started a new change. I cut my hair, and joined some clubs in school, and basically my drug use and went underground as my parents concentrated on my older and younger brothers.

Also I can remember at the time, at various times, going to my mother and sitting in the den and talking to her about drugs and alcohol and different things, you know, and at that time that was my cry for help.

I wanted help and that was my way of saying that I wanted out. I didn't expect this. The summer before college I experienced a series of blackouts and near overdoses and flashbacks of LSD and I decided that drugs weren't for me any more and my addiction now changed to beer once again. I went back to alcohol that I had left so many years before.

I entered my freshman year at LSU, bound and determined to change my life because this is where I was going to make my big debut in life, leaving all my old friends behind and starting all over.

I didn't learn anything, though, at LSU. I learned how to drink. My first semester I had a 1.1, second I pulled out maybe, back up to a 2.0. I had never made less than a C in all my life all through high school and for the first time I had a 1.41. I began to toast my hangovers with a Budweiser—the breakfast of champions is what we used to call it.

But, it is kind of a trip. Well, I remember sitting in the dark shadows of a certain bar with a certain friend and kind of joking over, looking over at him and saying, "You know, if we keep drinking like this we will become alcoholics," and I remember him sitting there laughing, what makes you think you are not an alcoholic? And I knew he was kidding, you know, but I knew deep down inside that he was right, too. I knew he was right.

Then the miracle happened. May 29, 1981, after some heavy intervention, I was admitted to the Adolescent Chemical Dependency Unit of Baton Rouge. There I stayed in a sterile environment about 42 days and for the first time in so long I felt so free and so loved and so understood and it is undescribable the feelings, coming from a drug addict and alcoholic, it is a relief.

After the unit, I was reunited with my parents and we spent a whole lot of time making up for lost time and within the next 6 months both my brothers returned from the halfway house and for the first time we were family. We were not perfect, but we were family again.

The only thing I can say is that recovery hasn't been easy for me. I wish I could say it has been, but it has been very rewarding, very, very rewarding because it is sobriety that I have now and I know I understand that, and a relationship with God that I never thought I would have.

And I have a family today. And I have a whole lot of very, very special friends, and friends I can call at any time and talk to. But more important for me today is, I got a choice and that is something I never had as a youth. I never had it. I never had a choice. That is all.

[Prepared statement of Bret West follows:]

PREPARED STATEMENT OF BRET WEST

My name is Bret West and I am a recovering alcoholic and drug addict. The one thing that I am not is an expert on alcoholism. A little less than 4 years ago, a miracle happened to me; I stopped drinking. It was a definite turning point in my life. The 6 years preceding this point, were some of the loneliest, craziest, and most desperate times of my life. I am very grateful to be here today for it's due to the grace of God, my family and a whole lot of people that I stand here alive and sober.

My parents were what I would call your average parents; they were church-going, they didn't fight, they were very supportive and above all, did not drink. I was brought up with some strong morals and ethics. My friends were plentiful, and my life seemed very normal.

Being a middle son of three sons, I received less attention than my older brother, who had some learning disabilities and my younger brother, who was constantly acting out. Somewhere along the line, I realized that I could get more attention by making good grades and participating in sports. I became the "Family Hero". I was the spitting image of the "All-American Kid"; athletic, outgoing, good grades, all the way down to the red hair and freckles. Life was very pleasant and carefree. Who could ask for more?

As I reached the age of 12, my life began to change. I started junior high school where I met many new friends and for the first time became interested in girls. It was also the first time that I became associated with people who drank or did drugs.

As I was entering my adolescence, I began to take a closer look at myself. All the insecurities of puberty were setting in. I became more and more unwanting of my red hair and freckles. The fear of girls became greater. I had so many questions and so few answers. Afraid of consulting with my parents, I relied on the information obtained from overheard conversations of my peers.

I'll never forget the night I had my first drink. It was the summer of seventh grade. I went to a party at one of my friend's houses where I sat petrified on the couch. Everyone was dancing and having a good time with one another. I became withdrawn and felt as if I was on the outside looking in. I felt ugly, scared and unwanted. What a night—I was wishing that I had never come.

I went outside with a couple of my buddies to claim the beers that we had stashed in the ditch earlier that afternoon. I figured that what I was doing was wrong, but it seemed like the "cool" thing to do. After drinking the beer, we all went back to the party. I noticed a definite change. All of a sudden, I was good looking, bold and witty. What would this party do without me? I could converse with girls easily and became the life of the party, but more important I forgot about my problems. That night, I thought that I had found the answer to all dreams. Those dreams, within the next few years, were to become a living nightmare.

Already an alcoholic pattern started to develop as the next weekends were to consist of obtaining that euphoria that I had felt that first night. I began to become disinterested in family activities. Within the next year, I dropped all outside activities such as sports. Getting drunk was becoming a No. 1 priority. My lower grades were evidence of that. By the time I had reached the ninth grade, I had already had my first joint of marijuana, the one thing that I swore that I would never do.

The trilogy was well at hand as my life began to decay morally, physically and spiritually. The pride that I had once had for my father was all but diminished. My mother had become a nag and I the rebel. I couldn't understand my parents' need to govern my life. Communication came to a standstill, as our conversations consisted of nothing more than a series of questions, acquisitions and heated arguments. I used to lie in bed upstairs, withdrawn, listening to my parents fighting with my older brother who was also into drugs. What had gone wrong? Why did life seem so crazy?

My use of drugs continued. At sixteen years of age I was taking stimulants, downers and eating hallucinogenic mushrooms. A far cry from that "All-American Kid". Getting high became my number one priority, even thought I maintained good grades and a part-time job. Good grades only meant less hassle from parents. A part-time job meant money to support my habit. I become completely exiled from my entire family. My home life consisted of nothing more than room and board. My blood was running cold, as the only association that I had with my brothers was to use them and their dope to get high. I felt the tug-of-war of emotions within me, but I no longer felt in control of my life.

By the time I had reached my senior year, I wanted out of my dilemma. Being called "a head" was no longer a compliment, but rather an insult. I cut my hair and joined a couple of clubs at school. My parents no longer hassled me, as my drug usage went underground, and they concentrated on my two other brothers. I can remember talking with my mother for hours at times about drug usage and other related things. It was a cry for help, but my mother couldn't see that at the time.

The summer before college, I experienced a series of blackouts, near overdoses and flashbacks. That marked the end of my heavy drug usage. Beer, once again, became my drug of choice.

I entered my freshman year at LSU, bound and determined to leave my old reputation behind and to get a fresh start on life. A geographical cure was not the answer. I couldn't run from myself. My drinking had become progressively worse as I began to toast my hangovers with a Bud Tail-Boy, the breakfast of champions. In all my life, I'd never made less than a "C" in any class and for the first time, I had a grade point average of 1.41. The following semester I managed to pull my average up above a 2.0, but my drinking habits were only altered slightly.

Sitting in the dark shadows of a bar, I remember telling a friend "If we keep drinking like this, we're going to become alcoholics". He chuckled and said, "What makes you think you're not one already?". Even though he was kidding, deep down inside I knew he was right.

Then the miracle happened. On May 29, 1981, after some heavy intervention, I was admitted into the Adolescent Chemical Dependency Unit, at Baton Rouge Chemical Dependency Unit. There I stayed in a sterile environment for 42 days. For the first time in many years I was free. I felt loved, cared for and understood.

After leaving the unit, I returned home where I was reunited with my parents. We spent many hours making up for lost time. I continued to associate with other adolescent alcoholics like myself. Within the next 6 months, both my brothers returned from their halfway houses, and for the first time in 6 years we were a family again.

Recovery has been a long, hard road to follow. Learning to live life on life's terms has been quite a challenge. It has not been easy, but it has been very rewarding. Because of sobriety, I now have a family. I have a new relationship with God that I never thought I'd have, and I have friends, something that I never had when I was using.

Chairman **Miller**. Thank you. Thank you very much, Bret. Thank you for sharing your experience with us. I understand that your father is accompanying you this morning. I would certainly invite him to testify if he has anything else he would like to say. This is unexpected I know. Certainly I want to acknowledge your presence.

STATEMENT OF DON WEST

Mr. **Don West**. Good morning.

I would like to thank you for allowing us to be here and to tell you what has happened to us. Can you hear me? OK.

I don't know as I can add a whole lot to what they have already told you except that to tell you that to try to convey to you the sense of frustration that we felt in that we knew that we had done all the right things in bringing these boys up.

I had gone places with them, taken them to the museums, to every kind of event, Indian guides, camping, I read the stories of the Bible to them three times, they probably knew the Bible better than anybody. So they still got into drugs.

So those people who think that, well, it can't happen to my family because we are doing all the right things—it can. The peer group of these kids has a lot more influence once they are past 12 years old, is a greater influence than anything that we have.

The only thing, I really felt like our three sons, I saw them going down the tubes, going down the drain, no hope. When they tried to talk to us about intervention and we went to intervention classes, I said, it won't work. There is no way, they will just get up and walk off.

But it did. Everything they told us to do worked. Anything that you ladies and gentlemen as Congressmen can do to help improve and spread this program of chemical dependency units would be the greatest thing you could probably do for this country, because we don't have to worry about the Russians, all they have to do is sit over there and wait for the drugs to take over America.

So there is hope for all these people who have kids who are involved with drugs. And I would like to tell this little story. My son and I have heard it so many times, but you know, I have heard this story of the prodigal son hundreds of times, and I thought I knew how that man must have felt, but I didn't until I really did him one better. I got three sons back that I thought were gone.

Thank you.

Chairman **Miller**. Thank you, Mr. West.

Marjorie.

STATEMENT OF MARJORIE

Marjorie. Thank you. Can you hear me?

Chairman **Miller**. Make yourself comfortable.

Marjorie. Thank you.

Mr. **Miller**. Welcome to the committee.

Marjorie. I am Marjorie, a cross-addicted alcoholic. What that means is I am an alcoholic and Valium addict. I am an adult child of an alcoholic and have parents who were alcoholic and co-alcoholic.

I would start by saying I was raised in a home where alcohol was abused. My father was a binge drinker; a little different from a regular alcoholic in that there were times he functioned normally and there were times he was totally oblivious to what was going on.

He would drink to the point where he would become a vegetable. As children we didn't really understand what was happening. We found out that when my dad would drink we didn't have any rules, or he would change the rules under which we were being raised. We could get money freely; we could get freedom; we didn't have to clean the house, and we didn't have to go to school.

When he wasn't drinking he was very religious. Both my parents were very religious, and we had a set routine, chores and guidelines that we had to go by.

I feel really grateful that my parents were both very loving and very open with us and when my dad was sober things were really nice for us. When my dad would start drinking we were liable to end up anywhere.

Many times—he was the type where he would tell my mother he was going out for a loaf of bread and he would stay away for a few weeks. Sometimes he had us with him; he didn't really mean any harm, he was kind of happy-go-lucky, and he would take us with him. We would go visit my relatives in North Carolina or we would go to Virginia Beach and visit friends, and I know it kind of left my mother hanging lot.

There were times when my mother went through all kinds of things to try and stop my dad from drinking, to the point, sometimes, where we thought she was going to kill him. We thought she was trying to poison him. She would water down his bottles, put vinegar in it, hot pepper, any combination of things to try and make him sick so he would stop.

He would drink to a point where he would just lay in a chair and sort of vegetate. He wouldn't eat, he couldn't talk, and he didn't recognize any of us. Sometimes this would last for as long as 3 weeks. As we got a little older and his alcoholism progressed there were times when he was violent or he would expose himself to violent situations. We couldn't really count on what sort of reaction we were going to get from him.

I feel like there were many times when I was growing up where I experienced traumatic events, and I felt shocked at some of the things that were going on.

One of the experiences I had was that my parents were both at work and there were five kids. We were home alone, and my brother was run over by a school bus.

Chairman **Miller**. You're are doing fine.

Marjorie. You know, we didn't find out until a day later whether he was going to live or not and there was nobody at home—sorry, I didn't expect this.

There were other things, there were fires in the house, my father would fall asleep smoking, and we woke up one night and my mother was dragging us all outside.

Sorry, I am losing it here.

Chairman **Miller**. You are doing fine, Marjorie. If you want to take a drink of water, fine.

Marjorie. I will probably drop it.

Sometimes I would come home from school and there were strangers in the house, sometimes there were people I didn't know, my parents had a lot of parties; there was constant chaos in our house. There was no structure whatsoever.

As I started getting older I found that I started becoming more and more isolated from people and I was the child that was responsible, so I would clean and do the cooking. My mother, she really was a sweet and wonderful person, and a typical co-alcoholic. She didn't know how to deal with anything, so she would just stay at work most of the time. It really became unbearable for her at home with five little kids and a drunk husband. There were times where he would hit my mother—my father didn't beat her and it was kind of a joke for a man to slap a woman or choke her or push her, it seemed it was normal—that was how I was raised that seemed normal, so that didn't seem abusive to me.

I grew up with a fear of people because I felt like to love somebody, to open myself up to somebody meant that they would hurt me.

I know when my dad was sober he would never hurt me, but when he was drinking I just couldn't count on how he would respond to me.

As we got older and we got into high school, I remember my sister, my younger sister, would drink at home. I can't tell you where she would get the alcohol. It didn't come from my parents because my dad would drink his up.

It's easy for kids to get alcohol. It is easy for kids to get drugs. Other parents, I have found, would give us alcohol, other parents have given my children alcohol. I started drinking in high school, which to me, seems normal. Being exposed to the kind of alcoholic I had been exposed to, somebody who drank regularly was not alcoholic; if a person could function, or if a person didn't get crazy or make animal noises or have food stains all over them, they were not alcoholic.

When I started dating I gravitated toward alcoholic men, and I started, in my late teens, going downtown to bars and dancing, and I can't ever remember not drinking. I didn't really get drunk; I was not a fall-down drunk, I didn't have blackouts at first or anything like that.

I started spending a lot of time downtown just at bars meeting people and dancing. I met my first husband in a bar and he was, a drug addict and alcoholic. He was very charming, much like my father, very nice, when he was sober. When he was drinking he became very violent.

I was married to him for 4 years, but I can only recall 1 year of that. He became extremely violent, very hostile when he was drinking and he would scare me to death. I remember hiding under the bed from him when he would come home. I would leave him and try to go home to my parents. I would tell them what was going on, and my mother would tell me that that was normal. She had experienced that and I was being very immature, and I needed to go back to my husband. They didn't want any divorces in the family.

I remember telling my husband once I was going to leave him so he hung me out of a window, told me if I wanted to leave that is how I would leave.

One time he set my dress on fire because he didn't like it. Many times he tore the house up. He was the type that would go out for a loaf of bread and come back 6 months later, and I think that is why the timeframe of my marriage is really mixed up.

I spent a lot of nights sitting up trying to sleep making sure he didn't break in. He used to break in once he would leave. I would change the locks and everything, and he would break back in where I was living.

I called the police on him many times, and they told me since he was my husband they couldn't help me. I spent 4 years living in fear. Somehow I was drinking this whole time. I started going to the doctor for anxiety problems and he thought I was nervous.

I would wake up in the morning feeling nauseated; I would shake and feel dizzy. Then when I would go to a doctor and tell him what was going on, he would tell me it was my nerves. They started prescribing Valium.

There was a time when I was living with my first husband, they put me on Stellazine because I had severe anxiety attacks and I became very depressed.

I was really afraid. No one ever asked me if I drank. No doctor ever asked if I drank at night. It never occurred to me to tell them because it never occurred to me that it was a problem.

I wasn't doing what my father did and that was the only kind of alcoholism I could relate to. Eventually I divorced my first husband, married a second husband who did not drink or take drugs. I had trouble relating to him at all and I was a very isolated person. That marriage did not work out.

Once I left my second husband I started back to the bars again. I didn't really get involved with the people at the bars because I was afraid of them, but it was something to do besides sit at home alone and I enjoyed going out and being around people and dancing. And along with that came the drinking which I really didn't think anything of because I wasn't drinking like my father, never had a DWI, was never in jail, and have never been in any trouble in my life.

All of a sudden I found myself feeling very anxious all the time, very sick, and really afraid and I wasn't sure what I was afraid of.

My use of Valium started increasing. I reached a point where I was taking a pill every day. I don't like to think that I abused Valium—I took it exactly like I was told, I never took Valium to get high, I never doubled up. I took them just like the doctor told me to take them.

I ended up taking a 5 milligram Valium four times a day. The doctor said, don't drink while you are taking Valium during the day so I didn't. I would take the Valium during the day and I would drink at night and that made sense to me. I didn't take a pill and then take a drink behind it. I was very ignorant about how alcoholism and drugs work together. Very quickly the Valium and alcohol started causing physical problems, and I began getting hives or what they call angioneurotic edema and the doctors then put me on Atarax.

They said when you take the Valium, don't mix the Valium with the Atarax and don't drink while you are doing either one. So I would take the Valium during the night, I would drink in the late evening when I was out at the bars, and come home and take Atarax.

And I was doing what I was supposed to do, at least in my own mind. Within less than a year I was physically ill to the point where I was walking into walls, I had lost my memory, and I was having a hard time functioning at home. I was able somehow to get up and go to work and hold down a job. I had two little girls and somehow I had always been able to take care of them. feed them, clothe them, and shelter them, but emotionally I just was not there for my children. Somehow, I had trouble figuring out what was the right thing to do as a parent because I had no guidelines, I had no role model. In 1975 my father had stopped drinking; he had had a spiritual conversion and he started to straighten up his life.

I began to drink alone in the house. I had a job where I worked in collection and foreclosure, and had to travel out of town. I would drink in the hotel rooms by myself, and I started hiding that because my family didn't think I had a problem because they were used to the way my father drank. My family was really concerned about the Valium.

I passed out one day at work, and was taken to the doctor's and they wanted to put me on more pills. Somewhere inside I just couldn't take any more. At that point I didn't want to feel anything any more. I was just sick and tired which is how I had felt all of my adult life.

The next thing I knew I ended up in a Kolmac Clinic, which is an alcoholic treatment center. I was really confused because I didn't think I was an alcoholic. I knew I had a problem with Valium, I had tried to stop many times on my own and I just couldn't. I felt like I needed it to get me through the day. I felt like I needed it to give me courage, I felt like I needed it because I felt like I was going to fly out of control most of the time. After I got into Kolmac Clinic, it took me 2 years to start feeling just OK, or comfortable. People coming off Valium have a more difficult time detoxing than somebody who is a pure alcoholic. I had to get back in touch with my feelings which I had not felt for some 10 years now.

I still struggle on a daily basis to try and recognize what my feelings are and how to relate to other people. I have not been able to have an ongoing relationship with a man because I am afraid of them and I don't trust them. I was in the Kolmac Clinic and I attended a fellowship of recovering alcoholics. I was also seeing a psychiatrist because of the anxiety problems, caused by being an adult child of an alcoholic.

Two years into all of this my daughter exhibited all these changes that Dot was talking about in Bret. My daughter was always wonderful, helpful at home and delightful to be around. She started sleeping a lot, eating a lot and being very belligerent. Not having a good role model to go by, I didn't handle all of this very well and I would have violent outbursts. I felt very frustrated angry and betrayed by her because I didn't understand what was going on. A friend of mine had had a daughter who had gotten into drugs and alcohol and he recognized the same pattern in my daughter. He put me in touch with the Montgomery County Health Department, and we got into a program called IDAT.

I was so willing to have help at that point. I had lost control of my family. I didn't know what to do with my daughter, I couldn't control her. She was skipping school, failing, getting into fights, and I was fighting with her. We had no relationship at all and at one time we had been really close. Once I got into the IDAT Program with Montgomery County I found out I didn't know how to be a parent, I had no idea how to relate to my kids. I had been a good person, I had been there with them and provided for them, but there is so much more that needs to be done with children, I was just unaware of.

The IDAT group taught me parenting skills. Other programs have taught me coping skills. I have not had a drug or a drink for 4 years now and my daughter hasn't had a drug or drink for a year and a half and my father hasn't for 10 years.

We are all working on living more constructive lives and I think I am really grateful for the opportunity to recover and to get well because most of my problems were just—I was just unaware of how alcohol affected me or my family. I don't resent my parents. I love them dearly. They are really good people. Both my parents have alcoholism in their family and it feels like our whole family is getting better together, but through different organizations.

My parents are very active in the church. I am very active in drug and alcohol groups. I am still in therapy with the Montgomery County program. I go to fellowship of recovering alcoholics. I go to meetings for adult children of alcoholics. I still see a therapist individually. I have become extremely comfortable over the last 4 years and I have a relationship with a higher power, which I choose to call God. Life has become very beautiful for me.

I just bought a house last year, and a new car. I have a new career and my kids are happy most of the time, I am happy most of the time.

I get a little nervous doing something like this but I am seldom anxious anymore. I have been taught how to think in different ways and how to change my attitudes and a lot like Bret's, I have a choice to be different. There are programs out there that can help people like me who were really uncomfortable and afraid to learn new ways to think and live. It does make a difference. People do change.

Thank you.

[Prepared statement of Marjorie follows:]

PREPARED STATEMENT OF MARJORIE

Growing up in an alcoholic home has contributed to problems I have had as an adult with parenting, relationships and my own personal inner comfort. As a child, it was difficult to predict what would happen next, as the rules were always changing. My father was a binge drinker and once he took a drink he was off and running for the next 3 weeks. Often I would see my father passed out in a chair, dirty, unshaven, food spots on his clothing, cigarette burns and dirty dishes all around him. He would make noises and often confuse us with other people. When it came time for him to sober up, he would get "DT's" and get really sick. Before he would get to the point where he would pass out, often he would like to go out and take us with him, much to my mother's dismay. He would tell my mother, for instance, that he was going fishing at Chesapeake Bay, and we would end up in Virginia Beach or North Carolina. We would miss a lot of school while my father was drinking and our home life was chaotic. When we were very young, both parents worked and we went through a series of maids and/or babysitters. Some of them were abusive. As we got older, we began to do the cleaning and cooking on our own and we had little time for play or studies. Often I would be up until 2:00 A.M. working on my homework.

There were many arguments and tears and we never knew quite where we stood. Some of the more traumatic events that I can remember are as follows:

1. My brother was run over by a school bus while my parents were at work. The neighbors called an ambulance and we watched my brother leave not knowing if we would ever see him alive again.
2. The kitchen caught on fire while my parents were out one evening. My older sister and I got the younger children out of the house and tried to put the fire out, but we were unable to.
3. We lived in Maryland and my dad took off with us one day to North Carolina, unannounced. When we arrived at my grandmother's house, my father slapped my aunt in the face and she tried to stabbed him with a butcher knife. I got hysterical and started screaming which diverted their attention on to me and they both started yelling at me. I can't remember how the incident ended.
4. My dad got in a fist fight with the neighbor and was carted off to jail.
5. My dad passed out on the couch while smoking. The couch caught on fire and the house was permeated with smoke. My mother woke us all up in the middle of the night and dragged everyone outside and the burning furniture.

There were five children and we spent a lot of time together, alone. I felt isolated from other children at school and did not allow many of my friends to come to our house; Partly because I never knew what condition my dad would be in, or how the house would look. I remember feeling inferior to the other kids because they dressed so nicely and their homes were clean and pretty. Our clothes were ragged and hand-me-downs and I remember very early on feeling embarassed about the way I looked.

My father owned his own business and my older sister and I took turns working for my dad. I was probably around 9 or 10 years old when I started working with the public. Somehow I managed to maintain average grades. I never participated in after school activities because I always had responsibilities at home.

When my father was drinking we had a lot of freedom and we ran wild. Other times my father was very religious and very strict. We soon learned to manipulate him into drinking when we wanted to do something he would not ordinarily allow us to do. My mother did the same and was often treated as one of the children. When we were caught doing something wrong we would be spanked either by hand or by the belt, always by my father, never my mother; or we would be slapped across the mouth.

I started drinking in high school as did many others. I drank lightly in the beginning and did not have any alcohol related problems. I met my first husband at a nightclub and married him 6 months later, mainly to get away from home. He turned out to be an alcoholic and drug addict. When he was sober, he was sweet and charming; but when he drank, he became violent and destructive and would go into blackouts. I was married to him for 4 years, but I can only recall one year. I started going to a doctor for anxiety problems, because my husband was violent and abusive towards me and they put me on Stellaznie for a short period of time. Later they put me on Valium. I kept leaving my husband and would go home to my parents who would tell me that what was going on was normal and I became very confused and would go back to my husband. I believe this went on for 4 years. I met another man whom I married when I was 25. I also met him at a nighclub. During the 4 years I was married to my first husband, I was out every night at a bar and on Valium during the day. During the four years I was married to my second husband, I did not drink, but I did take Valium. I left my second husband in July 1977 and began going out to the clubs again and drinking nightly. By this time I had two little girls. I have always been able to hold down a good job and support myself and my children.

In 1978 I met a man who had gone through detoxification at Montgomery General Hospital and regularly attended AA. He recognized my problem and advised me to attend some AA meetings. Because I did not get into any trouble, and because I did not drink like my father or act like my father, I felt that I did not have a problem with alcohol. I knew, though that I was beginning to become dependent on the Valium. Many times I told myself I would stop, but somehow could not. The reason the doctors continued to prescribe Valium was because I would wake up in the morning feeling nauseated, shaking and anxious and dizzy. Since they could not find anything physiologically wrong with me they felt it was my nerves and therefore continued to prescribe Valium. At no time did any doctor or anyone else ask me if I were drinking at night and it sincerely never occurred to me to tell them. In 1979 the man that I had been seeing in AA overdosed on heroin and died. In 1980, I began to swell in "giant hives", which the doctors referred to as Augioneuroticedema; so, they prescribed Atarax. I was now taking one 5 mg. Valium every 4 hours during the day, drinking from 9:00 to 2:00 and taking 100 mg. of Atarax every night. Soon I became very physically ill, barely able to function at home, but I did manage to get to work. My memory became fuzzy and I could not remember when I had taken my last pill, so my children, family and boyfriend all helped to remind me when my next pill was due. I began to lose my motor skills and started walking into walls, and at times would have severe attacks of dizziness and severe anxiety; my mind could not stay focused on anything and I became very depressed. When I called the doctors again, they were going to increase my dosage of Valium. I told them "NO More". The doctors told me I could not stop taking the pills and proceeded to put me into Kolmac Clinic where I was treated for alcoholism and drug addiction.

Through the support of Kolmac Clinic, a psychiatrist and AA, I began to learn about the disease of alcoholism. It took two years of AA, group therapy and individual therapy before I began to become somewhat comfortable and clear-headed. During my third year of sobriety, my 13-year-old daughter became involved with other kids using drugs and alcohol and she soon was using marijuana and alcohol on a daily basis. It took me several months to recognize the change in her. Prior to her using, she had never been in any trouble, was an above average student and was never rebellious. She soon began to steal from me, eat a lot, sleep a lot and became very belligerent at home and at school. A friend of mine whose daughter had also been on drugs recognized the symptoms and gave me Anne Rayburn's phone number at the Montgomery County Health Department. We enrolled in their IDAT program, where I began to learn some parenting skills. They also had us in family therapy and eventually I began individual therapy again. My daughter has not had any drugs or alcohol since October 31, 1983.

Through AA, Kolmac Clinic and Montgomery County Mental Health Department and Meetings with Adult Children of Alcoholics, I have learned many new things about myself. Particularly, how to change the way I think, coping mechanisms which I had not known previously, new parenting skills and how to live a more responsible life.

It is difficult to put on paper all the feelings that are created in children from alcoholic homes, but suffice it to say, they do grow up differently than "normal" children.

My father no longer drinks, and is very active at Church, and has been sober for almost 10 years. I have been sober for 4 years and my daughter for about 1½ years. We are all learning how to live more productive and happy lives. None of us were what people consider an alcoholic to "look like" or "act like". My father and I were both functioning alcoholics.

I am still at times very isolated and have trouble with male/female relationships. I am now working as a Loan Officer for a mortgage banking company, have bought a house and a new car in the last year.

Chairman **Miller**. Thank you very much. Can I ask you if you will switch chairs with Beverly so she will be in front of the microphone?

Thank you again for your appearance here.

Beverly.

House of Representatives,
Select Committee on Children, Youth, and Families,
Washington, DC, April 3, 1985.

Marjorie
Silver Spring, MD.

Dear Marjorie: This is to express our personal appreciation for your appearance before the Select Committee on Children, Youth, and Families at our hearing, "Alcohol Abuse and Its Implications for Families," held here in Washington March 18. Your participation contributed greatly toward making the hearing a success.

The Committee is now in the process of preparing the transcript of the hearing for publication. It would be helpful if you would go over the enclosed copy of your testimony to make sure that it is accurate, and return it to us within three days with any necessary corrections.

Also, we would greatly appreciate your answering the following for the record: In what ways have you been able to help your younger daughter understand and avoid the problems of alcohol abuse that you and your sister faced?

Let us again express our thanks, and that of the other members of the Select Committee for your testimony.

Sincerely,

George Miller,
Chairman, Select Committee on Children, Youth, and Families.
William Lehman,
Chairman, Task Force on Prevention Strategies.
Lindy (Mrs. Hale) Boggs,
Chairman, Task Force on Crisis Intervention.

The ways in which I have helped my younger daughter to understand and avoid the problems of alcohol abuse is to share with her my experiences and her sister's experiences. She has been included in all the recovery programs as well as occasionally attending Alateen. I have been open with both of my children about my childhood and have shared with them the concept of Alcoholism as a disease. I have also explained to my children some of the problems they may encounter when exposed to people who are drinking and how to avoid those situations, as well as keeping the lines of communication open between ourselves so that they may feel free to come to me with their problems.

Marjorie.

STATEMENT OF BEVERLY FARIA, PARENT, CONCORD, CA

Mrs. **Faria**. I am Beverly Faria, and I am an alcoholic.

I am 28 years old and I have three children, a 9-year-old, a 4-year-old, and a 3-year-old.

I was raised in a normal family with two brothers, a twin sister, a mother and father in a middle-class neighborhood with no alcoholism in the immediate family, but my uncle was an alcoholic and died of alcoholism.

Chairman **Miller**. They cannot hear you in the back of the room. I recognize the difficulty of the testimony that all of you have given us, but to the extent you can speak up we would appreciate it.

Mrs. **Faria**. I was married when I was 18 and I remember my first drink. My first drink, I was 21 years old. I was like Bret, it made me feel confident. I felt like I belonged. I just had a good feeling about myself.

And I had one child that was very young, and it seemed like the alcohol—when I had my first drink every time I had to go do something or be around people I felt I had to drink, I felt more confident when I drank and I felt accepted by other people when I drank.

As years went by I had another child and I was a housewife at home and I started drinking every day as time went by. I could see that I was alcoholic. I knew I was. But I wasn't willing to do anything about it.

When I drank I became very belligerent and I was mean and real pathetic, and I started not getting along with my husband because when I drank I got mean, and it would be like I would have a few drinks before he would come home and I would think of things to argue about when he would come home and the family started not trusting me any more.

They would ask me, were you drinking, did you drink today? And I would say, no. You could smell the liquor on my breath.

My husband decided to leave for Los Angeles. That was because he wanted to pursue his career and I just drove him off. I stayed home with all three of the children and that was real hard. He would come back, my husband would come back every 3 weeks and try to work things out, but I quit drinking for a while and I would be right back. I would say, "I'll quit, I am going to quit."

I would wait for a couple of days and he would come back and I would be drunk again and my drinking progressed and I started drinking in the morning and it just seemed like I was drinking all the time.

There was a glass right there for me to drink all the time no matter where I was. If I had to go out to go to the store I know I would drink enough that—because I knew I couldn't drink in the store, but I would have it in my system because I had to have it in my system.

Then I moved in with my mom. I was trying to control my drinking then and it was controlling me. My mom called the police and the police—I had the children in the car, I was going to leave for Los Angeles and see my husband and try to work things out and I had two of the children in the car with me, and the car, I was having trouble starting it, and the police came to my car asking me where I was going.

I told them I was going to Los Angeles, and I was drinking, belligerent, and so they took the two children and took me to jail and I got arrested for child neglect.

I still save that piece of paper so I remember. That is real painful, somebody that loves their children gets arrested for child neglect.

And when I was arrested I was taken to a detox and then later I stayed with a friend and two of the children went into a foster home and the social worker told me if I wanted to get these children back I would have to quit drinking and have to go through a program. I wanted those children back so I was willing to do just about anything.

So when I went through this program the social worker kept telling me, "If you want these children back you will have to quit drinking." After 2 weeks in the program I went back to drinking again. I went through a lot of hell for that. I wanted those children back, but I wasn't—I just couldn't quit. I just couldn't quit.

After about 4 weeks, the children being in a foster home, my sister quit work to take care of the kids while I tried to get well. So I was in this other program, too, and I was doing everything that they told me I had to do. I had to get sober. I had to go to work. I got a job. I was bringing home $112 a week, and the social worker wanted me to get my own place and I couldn't see how I was going to get my own place with $112 a week and raise these three children.

So I went back to drinking again. In that time I was drinking just before I went into this program that I am in right now, I was just—I was just plain insane. I was drinking, I was so drunk I didn't know where to turn, what to do and I was ready to commit suicide. I had went into the bathroom where I was and I sat in there and I couldn't see how I was ever going to get my children back.

I didn't see how I was ever going to stop drinking. I couldn't see how I would ever be able to stop drinking. I tried it. It didn't work. I was in this bathroom and I am sitting there and I will never forget this moment.

I saw a razor blade, I was ready to do it, I had cut part of my wrist and I thought about, so you are sober 5 months and it was a good time and I saw possible things happening, and I thought of my daughter and the two boys and my daughter is just the most beautiful thing you have ever seen and I thought of her, and I thought of all the people that are in AA and what all the people do to get sober and their lives get back to normal again.

And it was like something, like a breath came in me and I got up, brought myself, got myself to detox and that is where I am right now. I am in the program right now. And I got into the program, and I am out of the program and I have been sober 10 months.

In this 10 months, it has been real hard and my children have been with my sister and they are with my husband now, but to get my children back they said I had to get sober, go through the program. I had to get an apartment or a house with three bedrooms, one bedroom, for the two boys and one for the girl and one for me.

And the children this January were supposed to go up for adoption because I couldn't get an apartment so I couldn't raise the kids. It was because I didn't have the money to.

So my husband has the children now, and my life is real good now, but he has the children. It is because I can't get a place to raise them. If the program could have let me bring my children with me or if my children could have went someplace where they could have stayed and I could have stayed where I was and got sober or they could have lived with me, it—I wouldn't have to lose them.

I am losing my children now because of this, because I am going through a divorce and he is watching the children, he is taking care of the children, he is a good father, but the way the system works I am not—I don't know the word to use—that I am an unfit mother because I can't take care of these children in a home.

The reason I can't take care of them is because I don't have the money for a home and that he has the children. When I go to court to try to get the children back, I am going to have—have a real hard time.

I talked to the social worker, told her there was just no way I could fill these demands that she had and she—what she told me a couple of months ago before my husband took the kids was, well, the kids were going to have to go up for adoption. Here I did everything that she told me I had to do and the kids were still going to go up for adoption.

That is when I called my husband to try to come get the children, because I did not want to see them go up for adoption. I would rather they go to him than go up for adoption. So that is what I had to do to stay sober. I had to give up my kids to my husband so I could stay in the program and get well.

My life is real good now. I am going to school to become a beautician, and I know in the next year or so, I am going to be self-supporting. I don't know when I am going to get these children back, but when I do, I know I am going to be a good mother—as long as I stay sober, I will. I just want to share something that we have at our recovery home. And that is we alone can do it, but we cannot do it alone. I believe that is true with every alcoholic.

It is real hard out there. On the plane coming in here, it was really hard. You know, they had wine tasting on the airplane trip. Like you said, we have a choice. I don't have to drink anymore. At my motel, we had a real good sale on wine. It was a real good deal on a carafe of wine. And I can drink; I can have that drink, but I choose not to because my life is really good today. And I am really glad to be here. Thank you.

[Prepared statement of Beverly Faria follows:]

PREPARED STATEMENT OF BEVERLY FARIA

I'm Beverly, I'm an alcoholic. I'm 28 years old and have three children, 9 years old, a 4-year old and a 3-year old. I was raised in a normal family with two brothers, a twin sister, mother and father in a middle-class neighborhood. There was no alcoholism in my immediate family, but my uncle is an alcoholic and my maternal aunt died of alcoholism.

I was married when I was 18. I was 5 months pregnant. I didn't have my first drink until I was 21. I remember the feeling it gave me. I felt warm inside, I felt confident around other people. Alcohol made be feel good about myself and I felt accepted with the crowd I was in.

What I remember most is that every time I drank after that, I felt like I belonged. I felt like I fit in. After about 2 years, I started drinking every day. Every time a problem or situation came up I needed a drink to get me through it. And, that is when it started affecting my family. I lied, was mean, belligerent and started sneaking drinks. I would be confronted by my husband and family and I would say that I wasn't drinking when I was. I started to be a problem.

I was starting to lose trust, I was unreliable. My husband alternated between yelling at me and not talking to me at all. That was when I started sneaking and hiding my liquor. When I was 25 years old, he decided to leave and go to L.A. to pursue his career. I stayed home with all three of the children and he would come back about every 3 weeks. We would try to work things out. I would quit drinking for awhile, but by the time he was home for a couple of days I was drunk again. My drinking progressed and I was drinking in the morning. It seemed 24 hours a day, I was drinking.

I moved in with my mom and I was trying to control my drinking. But, by then, it was controlling me. After about a year with my mom, she tried to call the police. I was trying to leave to go to L.A. with two of my children. The oldest one was with his dad. The police came to my car, I had been drinking, and I was arrested for child neglect.

The children went into a foster home and the Social Service Department told me that if I wanted to get the children back that I would have to quit drinking. A month later my sister took the children as their foster mother. She had a 2-year-old child of her own. That was when I went into the Social Model Recovery Home for Alcoholic Women, After 2 weeks in the home, I drank and was asked to leave. I went into another recovery home, stayed there 5½ months, got a job, and was bringing home $112/wk. I just couldn't see how I was going to raise the kids on that. That is when I went out and drank again. I felt defeated, hopeless and helpless and just didn't see how I could do it.

I was out drinking for 1½ months, when I re-entered the first program. I had sat in a bathroom in a dark corner and I felt that I was never going to get the kids back. I was never going to be able to save enough money to get a place for me and the kids. I wasn't going to be able to ever stop drinking. And, as I sat in that corner, I looked up, I saw the razor blade and I was ready to do myself in. There was no way I could see things getting any better. Then I thought about my daughter and two boys and the 5½ months that I was sober and that I was happy and things were going to get better. I just had to give it one more try. And, whatever I had to do to stay sober I was willing to do. I got myself to Detox, I reentered the women's program with nothing on my mind except to get my children back and stay sober. My main thing when I entered the program was that I wanted the kids back. The social worker said that it was time for me to go get the kids back when I had been in the program about two months and she told me that I needed to get my own place, live there for 3 months, show adequate income and to be responsible. I thought I could do that. I thought I could just leave there and I would have it. I thought it would all be taken care of—that she would help me out. I had it all planned out.

I went into the office of the staff in the recovery home to tell them that I was going to be leaving, that I would be getting my own place and that I would be getting the kids back. I knew I had to get out of there. I had to get on my own because time was running out.

The more I talked about what I was planning to do, the more I knew it wasn't realistic. There was no money, I needed a three-bedroom house, (because I had a boy and a girl), and I needed to live in it for 3 months. I needed first and last month's rent, a deposit, deposit on utilities, adequate food, money for clothing for the children and myself, and transportation. I didn't have any skills and the only job I could get would be at minimum wage and probably part time. And, it seems like if I had to get a babysitter to go to work it would take my whole check. The more I talked about it, sitting in that office, the more I knew there wasn't a way I could do it. I knew I couldn't go into that situation and stay sober. I couldn't see how I was going to get to the AA meetings. I felt trapped and closed in again.

I talked to the social worker and told her that there was no way I could fulfill the demands that were made on me in such a short period and stay sober at the same time. She told me that if I couldn't do that, that the kids would go up for adoption in January. That was when my sister tried to get the children's father to take the kids. If he was going to take the kids that meant I was going to give up all my rights. I wanted to give up the kids to him instead of them being put up for adoption. When I was willing to let him have the kids was when I was willing to go to any lengths to stay sober. It took three months of discussion to convince him to take the kids. If he wanted them, he wanted them for good. He didn't want to give them back. I was willing to do anything just so they wouldn't go up for adoption. I knew if they went for adoption that I would never see them again. He finally agreed to take them. I was relieved that I didn't have so much pressure to go out and get a job which would support me and my three kids. I didn't have to do it immediately.

I always wanted to cut hair. Its always been a dream. But until now, I had the kids. I had to stay home and be a mother. I talked to Vocational Rehabilition, took the testing, and let them know how I felt and what I wanted to do. Up to this point, Voc. Rehab. was only willing to help with clothes, to go look for a job. After I gave up my rights to the children in order to maintain by sobriety, Voc. Rehab. became willing to support my desire to become a hair dresser and partially finance my schooling. I also got a grant. Voc. Rehab. helped me with my transportation money, books and clothing.

At this time, I am 10 months sober and have been in school 5 months. The recovery home has a 3 to 6 month program, with exceptions granted, and I stayed in the program 9 months. I had to leave the program as my personal program of sobriety was stable. (I tried to get on General Assistance and I was not accepted because I would have to go look for a job and turn in 12 applications a week and spend 2 days a week at the General Assistance office. There was no way I could do that and stay in school. I would have lost my grant at school). At this time, I am working for my room and board at the recovery home as the overnight staff and in this way I am able to stay in school, have a place to live, food, and support. I have no income and get spending money doing nails and permanents on the side.

I am going through a divorce. In the divorce, my husband wants custody of the children even though he has only had the kids for 4 months. He has a good chance of getting full custody of them because they are with him now. No matter how hard I'm trying to be self-supporting, my lawyer feels that my chances of getting joint custody are very slim. Even though I tried my hardest, did everything I could to be self-supporting, sober and a good mother, I'm still losing my children. Sometimes, I still feel I'm bing treated as if I'm still drinking and yet I've been sober for 10 months and I'm doing better that I ever had in my whole life.

In 10 months, things have been so good and I know that they can keep on going if I stay sober and work my program. But that is not entirely true. I have my self-esteem back, I have confidence, I have self-worth, I just don't have my kids. I have some resentments because for 1½ years the children's father rarely contacted the kids, did not send any child support payments to my sister or mother for their support, and did not show any interest in them. Now, he has them for 4 months and he is the good parent. The possibility is strong that he will get the full custody and I may get visiting rights. They are in L.A. and I get to talk to them once every two weeks at 6:00 p.m. for about 5 minutes.

In closing, I just wanted to say that I did everything that I was supposed to do to get the kids back. I just could not afford my own three-bedroom place and become self-supporting in such a short period of time. If I would have had the economic ability or if the recovery home would have had residential child care, the issue would never have come up and my children would have been with me, in my sobriety.

I'm glad I got to share my story and I hope this helps other women and their families so they can all go through recovery together and that they can all grow together.

I want to share with you a saying that we have around our recovery home. We alone can do it, but we can't do it alone.

Thank you and God Bless.

Chairman MILLER. Thank you. I want to thank all the members of the panel for the courage to come here and share your experience with us. I think it has been a very enlightening 1½ hours. I would like to recognize Congressman Lehman.

Mrs. BOGGS. I just want to say Marjorie's daughters, Stacey and April are with us. I am so proud to have them here, and I know how proud they must be of their mom. Would they like to be recognized?

Chairman MILLER. Come on. We will make you a star here. Thank you very much. Thank you for coming and supporting your mom.

Mr. LEHMAN. You are very courageous people. I would like, Mr. Chairman—I would be remiss if I didn't recognize at this time whom I should have recognized, John Daigle from our Governor's office in Florida, Director of the Alcohol Control Administration, Department of Health and Mental Hygiene, Chairman on Commission on Drug and Alcohol for the State of Florida. Glad to have you with us, Mr. Daigle.

Alcohol and marijuana, alcohol and other drugs, alcohol and Valium—in most cases it is not just alcohol. That is one thing we will have to recognize. It is a combination of these factors at work. I happen to be subcommittee chairman of the Appropriations Subcommittee on Transportation. We are very concerned about driving when intoxicated. We have written in our legislation that States will not receive their full funding for the Interstate Highway Program if they do not pass 21-year-old drinking laws.

I think you are very fortunate that you haven't been a factor in either the death or injury of other parties. You do not have to answer this now, but we would appreciate any help that you can give us in regards to what you think would be the best approach to the kind of regulations, the kind of laws, kind of efforts we should make to control driving when intoxicated, to control the number of deaths of people that are killed each year in automobile accidents.

Supposedly over half the deaths from automobile accidents are directly associated with alcohol. And if you would care to comment in any way on this problem of driving under the influence, or if you would write me any memoranda or letters that I could use as testimony for the record in our own subcommittee, I would be very happy to include that in the transportation subcommitee records.

Mr. Wolf, who is with us today on this committee, is a member of our subcommittee, and he also is aware of the problems of the National Highway Traffic Safety Administration that we fund and its efforts to reduce the deaths from alcohol on the highways. So whatever you want to comment on that, you may, but also give it to us in writing for the record and we would be glad to use it in this committee as well as in the Transportation Subcommittee.

Thank you, Mr. Chairman.

Chairman Miller. Mr. Coats?

Mr. Coats. I, too, want to join the rest of the members of our committee in applauding your courage and willingness to come here today and share your story. It is a meaningful story. In our search for ways to help, your testimony is very important. I am wondering if, Dot and Bret, you could share from your experiences any advice that you might give to other parents.

If parents came to you today and said, "What did you learn through all this that could be of help to us: we now have young kids, and we want to avoid that experience?" What advice would you give them?

Mrs. West. Well, I think the parenting discussions and groups they have are excellent. I find we mimic the behavior of parents we have had. And we try to raise our children according to the standards that we were raised. As I was saying in my speech, we are in a different generation. And some of those things are just not working with this generation, with this new environment that our kids are exposed to.

A lot of the help I got through CDU—they treat the whole family—had a lot to do with parenting skills. I think most of us who are—have kids that are alcoholic, drug addicted, so many times it is a family illness. We are lacking in parenting skill. It doesn't mean that we don't love our children or we don't care for our children, but we just don't have the skills, I guess, to share those feelings with them.

That was what I was trying to say. I love my children better than anything, but I didn't know how to tell them I loved them. I thought I was showing it, but I was so scared that I was protecting them all the time. I was so scared and projecting what could happen to them that I spent my whole time trying to control them—manipulate them and the environment they were in. And it just didn't work.

I never let them make their own decisions. And I don't guess they had the skills to make decisions by the time they got to the age where they needed that.

Mr. Coats. Is it fair to conclude, then, that treatment for the problem should involve the whole family?

Mrs. West. Definitely. I don't see how an adolescent who went through a unit could recover very well in a home that wasn't recovering.

Mr. Coats. Bret, I wonder if you could share with us on the same question?

Mr. West. Ditto what she said. Basically, if a parent came up to me today—I don't know if I really could tell them any answers.

Mr. Coats. Let me ask you this, Bret. You are going to be a father some day, and have three boys growing up. What are you going to do to raise those boys and try to prevent them going through what you went through? I know that is a tough question.

Mr. West. Yes. I don't know. I think a lot of it had to do with communication. Well, before I ever took my first drink, you know, I think it had a lot to do with just my own communication skills with my parents. I don't know what I am going to do if I am faced with the situation of raising three alcoholics. Probably just the same thing that my parents used for me to get sober. I really hadn't thought about that a whole lot.

Mr. Coats. Do you also agree with your mother that the whole family should be involved in working out the problem?

Mr. West. Oh, definitely. Definitely. You know, I think that it is a disease. It is not an issue of morals or ethics or anything else. And I think that is real evident, especially our family, you know. My parents who didn't drink—like I said, you know, before I started drinking I was the spitting image of the American dream kid, you know. It had nothing to do with the environment that I grew up with; had nothing to do with that at all.

I really don't think it had a whole lot to do with parenting. It is just a disease that affected all of us. Once I was engrossed in it as well as my other three brothers, it was just like a snowball effect. It just kept getting bigger and bigger. And it was just like everybody got involved in it, you know.

Mr. Coats. You still look like an all American kid. In your testimony you said, "Then the miracle came May 19, 1981. After some heavy intervention I was admitted to the ADC unit in Baton Rouge." What was the heavy intervention?

Mr. West. It was kind of a surprise more than anything. It was what they called a family week. I was in a family week with my younger brother who was already in treatment. The family week was basically addressing the family problems with the alcoholic. And I happened to be—I wasn't an alcoholic at this point, you see. I was still trying to be together.

The intervention was more or less getting me basically dry for about 3 or 4 days off of alcohol and drugs where my emotions were beginning to come up. And my parents, not telling me what a bad person I was or all the things that I did, but telling me the way they felt when I did them and talking about the feelings and the shame and everything.

I think that is what geared me towards sobering up.

Mr. Coats. So this was part of an organized weekend or week long program?

Mr. West. Yes.

Mr. **Coats**. It involved the whole family? And it was through that involvement you started really thinking through your feelings, and then decided on your own, voluntarily, to enter the unit?

Mr. **West**. Well, it was a little bit more; a little twist of the arm. I can't say—it was kind of a—for me, the feelings were I wanted help. And I knew I needed to be there, but at the same time, the disease, I suppose, was telling me, no, you don't need to be there. You are not an alcoholic—you know.

Mr. **Coats**. Was there a point in your projection experience where you had to make a decision on your own: I want to be helped?

Mr. **West**. Definitely. Definitely.

Mr. **Coats**. Did that come during that weekend? Is that what the miracle was?

Mr. **West**. No, no; my decision that I wanted help and I wasn't doing it for my parents anymore came through the treatment; I guess after about 30 days of being in the treatment. It is kind of hard to explain what actually happens there, but after about 30 days, I began to realize that I wanted a better life and that there was a better life, and that, I guess, a life on drugs and alcohol wasn't quite as grand as I thought it was.

Mr. **Coats**. What happens in that treatment? Can you just sumarize what is the most important thing that happens during the treatment phase that makes you able to turn around? And I open that question up to any of the three panelists, because you have all been through it. What happens when all of a sudden you just decide that that is not the life you want? You want to change, and that decision causes you to be able to go forward and stay sober and not return to that.

Mr. **West**. She mentioned one, just really important for me. It was the first time in my life I was able to get honest with myself and others. It is like I really didn't live in a reality back then, and the people. Being with another alcoholic and being able to sit there and tell somebody my life, all the secrets that I had never told anybody, was kind of quite an experience. The groups—it was just, for me, it was just trying to—a reeducation in life or something, you know. That was the big thing.

Mr. **Coats**. Let me just ask Marjorie and Beverly in concluding, as the chairman is getting a little nervous about my time, what happened that allowed you to make the switch over?

Ms. **Marjorie**. For me, what happened in treatment was that I needed Valium to feel OK; anxiety for me was a normal state. When I heard other people talking about their fears and their anxieties, I know it may sound silly, but somebody told me you have whatever it is within you to be OK, Marjorie. You will be OK all by yourself.

Well, I didn't know that. I thought I had to have alcohol or drugs to feel OK. I heard also that the feelings that I would have, the anxiety or fear or whatever, that they would pass and that was not a permanent state.

I felt like they were going to take the alcohol and Valium away and I would just be a mess. But when they said that it would be all right, and I would feel better and all the bad feelings would go away, I thought, well, I will try that, and if it doesn't work I can always take something again.

Ms. **Beverly Faria**. They said when I got into the program that you have to be honest with yourself. You have to be honest and honest with yourself. Once I got honest with myself, and I said how I really felt was when things—I knew things were going to be OK. The honesty in this program that we have, as long as I can be honest and know how I feel and deal with my feelings, it is OK.

Mr. **Coats**. Bret.

Mr. **West**. The one thing I guess I just thought about is the biggest thing was being OK, you know. A lot of it was like, for so long, I guess I was brought up like, you know, feeling guilty or feeling hurt, especially as a male, was not OK. And it was not OK to cry. It was not OK for all these different stereotypes. You know.

And I guess the big thing in the unit with which was the big turnaround was finding out that I was OK; that it was OK to feel the way I felt and it was OK to be ignorant in these areas of my life, you know. And that was my—it was my morals and my ethics, and me that I had to live with and not everybody else's. That was a real turnaround for me.

Mr. **Coats**. Well, thank you very much. You are OK with all of us. We really respect you and admire you for what you have been through and the way you have been able to get ahold of things.

Thank you, Mr. Chairman.

Chairman **Miller**. You will be surprised how rich you are. Most of us don't figure that out until we are 45 or 50 years old, but you are way ahead of the game.

Congressman Lehman asked what your impressions were of the effort we are making at the Federal level to require States to move the drinking age from 18 as it is in some cases, 19 and 20, to the 21 age level. Do you view that as being helpful?

Bret, you must hear from some of your peers. I know I hear from my sons a kind of pro and con argument there.

Mr. **West**. I don't know if it would help. I really don't. I think you are promoting the black market of drugs in that case.

Chairman **Miller**. By raising the age level?

Mr. **West**. Before I was 18 years old, a prime reason that I guess I didn't drink is I couldn't get it. But drugs were easily available, you know. It wasn't until I reached 18——

Chairman **Miller**. They are illegal at any age if I remember the law right.

Mr. **West**. Right; it wasn't until—it is 18 to drink. When I reached the age of 18 and entered college and everything, I kind of went off the drugs a little bit and came more on the alcohol. So I don't know which is worse. They are both kind of one and the same.

Mrs. **West**. Maybe the law should be chemical, not alcohol.

Mr. **Lehman**. Mr. Chairman—would you write me a little memo on that? I would like to have it just for our hearing record.

Mr. **West**. Sure.

Chairman **Miller**. Congresswoman Boggs.

Mrs. **Boggs**. Thank you, Mr. Chairman. Thank all of you so much for your testimony and being with us, trying to help us to help other families and other institutions and organizations.

Dot, there seems to be an intergenerational difficulty that exposes itself here. But are there any particular problems in yours and Mr. West's own family households as children that perhaps geared you away from being able to handle the drug and alcohol situation in your own family?

Mrs. **West**. Well, I grew up with the idea that alcohol—drinking was a moral problem. And I thought when my boys started drinking and using drugs that they were bad people. And my way of talking to them was always in the judgmental way. That is when I was talking about the parental skills. I didn't accept it as a disease, and I really began hating the kids.

I thought that they just—I was very angry. I thought they were trying to humiliate me; that they hated me. And I couldn't understand why they couldn't quit drinking or quit using drugs if they wanted to. I thought that it was something that they had a choice over. And I really just thought they had weak characters. I really didn't understand the problem at all.

And I just kept getting help and going to psychiatrists and all of this. And the feedback we were getting wasn't helping our situation. I just began feeling worse and worse about myself, because I was the mother of these three boys. And I guess that the way I handled it was all wrong. Our conversations were all very judgmental. And also, you know, we were raised with the idea that you took care of your own problems. And much of the time I was trying to take care of it by, you know, talking to them and judging them.

I certainly wasn't sharing those problems with anybody. That was taboo. That meant that I was a bad person if they were bad people. So I went through a lot of guilt and a lot of shame with this situation before we got help. I was probably sicker than the kids at that time.

Mrs. **Boggs**. Does a codependency develop among family members?

Mrs. **West**. Yes, I was codependent when I came into the marriage, I think, because my father was an alcoholic and it was just real natural to me to take care of people and handle problems and control people and to manipulate them. Of course, I went into the teaching profession and that helps, too, to cultivate those qualities.

Mrs. **Boggs**. Speaking of the teaching profession, can you tell us what the Baton Rouge school system is doing to address the problems of drugs and alcohol?

Mrs. **West**. Yes.

Mrs. **Boggs**. And is there any way the Federal Government can help in those regards?

Mrs. **West**. I wrote a note at the end of my report about that and decided since it was family, maybe I shouldn't bring it up. But I have served on the adapting team the last 4 years. The community has a care program. They donate hundreds of thousands of dollars to hire drug counselors for each school.

These counselors only come out about once a week. Then we have a group of teachers who worked on—volunteered to work. And we contact parents whenever we think that their children are harmfully involved in drugs. I tell you, I have been more alarmed this year than I have from the time I began to work with this council. We have contacted more parents of ninth graders who are heavy into cocaine. More of the children we are putting in treatment at this time are in the ninth grade.

When I first started working with this group, most of the kids we were working with were in the 11th and 12th grade. We are seeing more and more kids into drugs. In my classroom—and I teach the college-bound kids. This is just a guess off the top of my head—about 20 to 30 percent of the really bright kids that I teach all day are sleeping through my classes and they are stoned on drugs. And they are blatantly talking about usage of drugs.

And they write about drugs. And they know who I am, and that doesn't seem to phase them at all. And I have really gotten scared at how acceptable drug use has become in their society, because 4 years ago, this would not have been the case. They would have been hiding that type of thing, but you know, it is OK. I will sit in the back of the classroom and hear them talk about how drunk they got at Mardi Gras or how much pot they smoked during the weekend, or, you know, just anything.

We have more problems than we can possibly deal with. The problems are just escalating. I sometimes feel like we are just hitting the tip of the iceberg. I guess the problem I am having is that—I don't know if you are familiar with "Brave New World" or not, but it is a novel by Huxley that depicts the society in which the materialistic guide controls the whole world by chemical.

I am really beginning to fear that that is what is happening, because the brightest kids I teach all day are simply going down the drain. When we talk to parents, I am also getting scared again because sometimes the kids are telling us—the kids in recovery are saying, "Mrs. West, it won't do any good to talk to those parents because he gets the cocaine from his Dad's top dresser drawer." And that's true.

Then we talk to the parents and we cannot convince them to do anything about treatment for these kids, even though the kids sometimes want it. And these are not parents like, you know, in the gutter. They are people who are on our Governor's staff, or who work at LSU. I mean we are in the college area of town. Our high school is located in that area of town. And there is an enormous amount of drug usage among kids.

And I think that they are parents of the sixties, and that a lot of that has started at home. Now, that is not always the case, but we are getting more and more of that. And I am really scared with what is going on in our schools. I think, you know, any problem that we are having in education, I don't care whether it is discipline problems or dropout problems or low ACT scores. I think they are a pretty good indication of what is going on as far as chemical usage with our kids.

Mrs. Boggs. Is the school system doing anything to combat it?

Mrs. West. Yes; but as I said, the little bit we are doing is just getting the tip of the iceberg. We have a counselor who comes on campus once a week. She could be there every day all day and couldn't take care of the problems. I team teach, and I am out of the classroom sometimes 2 and 3 hours a day talking to parents. I will teach English to the whole group, maybe 50 or 60 kids at one hour. My team teacher will teach the other hour so I can go out and talk to a parent.

I am talking to them at lunch and I am talking to them after school. Sometimes I come up there at 6 o'clock in the morning and talk to parents. And we don't have enough time or enough help. Yes, our community, I think, is doing more than any community in this Nation. They said we are way ahead as far as, you know, recognizing and addressing the problem.

But it is just—the problem is astronomical.

Mrs. **Boggs**. Bret, is there anything that the young people can do to be helpful to their peers?

Mr. **West**. I don't know. I really don't.

Mrs. **West**. Attitude. May I say something?

Mrs. **Boggs**. Sure.

Mrs. **West**. Lyle Hisman was the adolescent chaplain at the unit where our kids went through. One of the things he said was that he thought that as a nation we were going to have to change our attitude toward alcohol or drugs. They are both chemical. The kids accept it as a way of life, and they cannot imagine going to a crawfish bowl without beer or doing anything without some kind of chemical.

I think it is an attitude that we have and that we hand down to them, the adults hand them down to the kids. Our media hands it out to them by the hour.

Mr. **West**. I would like just to say that as far as the I Care Program that the East Baton Rouge Parish has formed, I guess one of the things they have done for the young people is they have set aside a young people's—a place called Delta Haven. All it is, it is a place where young people can go without having to take a drink.

It is just a place where people can gather and converse or whatever—play pool. That is one of the other things that I—I really don't know if there is anything the kids themselves can do to help the other person other than helping themselves.

I know from my own experience, when I sober up, there was nothing I could do for my other friends who were still out there doing dope except keeping a little bit open, some kind of open communications and not really isolating too much from them, but not getting in the heat of the fire, so to speak. And a couple of my friends have come to the program and have sobered up since. But there really wasn't anything I could do but stay sober myself and, I guess, set some kind of example. I guess that is what you would call it.

Chairman **Miller**. Thank you.

Mrs. **Boggs**. Marjorie, when you had the giant hives, when Atarax was prescribed, did your doctor ask if you were taking Valium or know what you were taking?

Ms. **Marjorie**. He knew because he prescribed it all.

Mrs. **Boggs**. Thank you.

Beverly, you say in your testimony vocational rehabilitation was only willing to pay for hairdressing school after you gave up the rights to your children. Can you explain why Voc. Rehab wouldn't pay for the school before then?

Ms. **Beverly Faria**. Because it was going to cost me so much to—like get a babysitter, and that I probably wouldn't finish the school if I had the children at home because that was just too hard. Another thing is that it is real hard to trust an alcoholic because their chances are so—the rate is so small. And she told me that she would help me.

Once I told her, she told me she didn't want me to go into this field. She wanted me to just get the kids and stay home and take care of the kids, because if I—it would take too much training for me to go out and get training and there was nobody there to watch the kids.

After 6 months, after I decided to let my husband take the kids, I was 6 months sober, and then they decided to help me. And they have been a lot of help in my program.

Mrs. **Boggs**. Thank you. Thank all of you so very much.

Chairman **Miller**. Congressman Wolf.

Mr. **Wolf**. Thank you, Mr. Chairman. I want to thank the panel. I think all of you should be extremely proud; it took a lot of courage to do what you did and you should feel very good about yourself. There aren't many people in this country, I think, that would have the courage to do what you did today.

I have a lot of questions, but I am going to probably ask only one because the chairman has other people in the room. Ms. West, what you say bothers me. You seem to be not really optimistic about the future. I heard that same comment when I visited a drug rehabilitation program in my congressional district about 3 weeks ago during a recess.

They tell me the use of cocaine was up; acceptability was up; that about 2 or 3 years ago we were all feeling that maybe this trend had turned the corner, and maybe it had. The question I want to ask all of you is very simple. What do you think we should do—society, the government (State and local, Federal Government) to protect people who are not involved in drugs and alcohol abuse. I think we should continue to fund the programs that you have, and other programs to do what we can for rehabilitation.

What can we do to keep people who are not now using drugs from using drugs and alcohol? How do you stop drugs from taking over, as individuals? Do you have any thoughts as to what we should be doing as a society, a government?

Ms. **Marjorie**. I would say for me, had it reached my family at an earlier age—we are all just becoming aware of the problem and how it affects the whole family; that if more families were contacted, if there was better education, more advertising to reach the families. Alcoholism affects families in so many ways other than driving while intoxicated or—it just inhibits your whole way of living and your attitudes and your thinking.

It is real important to get inside the families, whether it be, I think, by the TV or advertising.

Mr. **Wolf**. Do you think the ads on television, when for example Budweizer has ads on television, do you think that has a bad effect on young people, encouraging them to drink?

Ms. **Marjorie**. I do. But I think that children pick up more from their families and their friends—their parents than anything. And I think parents do love their kids.

Mr. **Wolf**. Sure.

Ms. **Marjorie**. And they want to do what is right for them. They are just unaware. In our family, it was just an unawareness of how alcohol affects everybody. I think once learning that, it is easier for everybody to work together as a team to recover from the disease—it does take the whole family. It is difficult for an alcoholic alone to recover if you don't have the support of your family. And if they are doing the same kinds of things to set you up, you are going to get pulled right back into it.

Often, these families will fall apart because everybody is not getting help.

Mr. **Wolf**. So basically, you think it is education. Beverly?

Ms. **Beverly Faria**. I agree with her, too.

Mr. **Wolf**. How would you educate?

Ms. **Beverly Faria**. Schools, yes. Because I think if my children are, if they can see, if they are in school and they are learning—I didn't learn anything in school about alcoholism. I didn't know. I didn't know anything. But maybe I still would have went out and had to do what I had to do, but I had an uncle that was an alcoholic. But the progression in the disease—because what I know now, the education, I know a lot of education on alcoholism now.

Now, I see it. But if I would have known before, I think I would have gotten help sooner, because the progression is, I just can't believe the progression, what I have learned on the progression part.

Mr. **Wolf**. Bret, what do you think?

Mr. **West**. I agree with the education and the awareness part of it. To be real honest with you, I didn't know what a chemical dependency unit—I have never heard anything about alcoholism until a month before I sobered up. That was because my brother was in one of these units. I really didn't know anything about it. Like I told you, some years before, I could have told you what drugs could do to you, but I never knew anything about the disease.

What do you think the best approach is to reach young people, leading sports figures, other students, teachers?

Mr. **West**. I think most people can relate from somebody sharing from an experience.

Personal experience?

Mr. **Wolf**. Personal experience. I know for myself when I hear somebody speaking maybe on alcholism, if he is a doctor, I am not really going to listen to him, but if he is a recovering alcoholic and drug addict, I am more apt to listen to him because he knows what he is talking about, and he is talking street language.

Mrs. **West**. I agree with the whole panel. We have in East Baton Rouge Parish our ADA council. And we have an education system going of prevention starting at the elementary. We have just began that. Our problem is personnel, having enough personnel to do the job appropriately. As I told you, we have one counselor who comes to see us on time a week and we have 1,200 students in our high school.

There are just too many problems for her to deal with 1 day a week. And, but I think what we are doing is good. It is just——

Mr. **Wolf**. Not enough?

Mrs. **West**. Lack of funding for enough personnel to do the job appropriately.

Mr. **Wolf**. Thank you. I want, again, to thank the panel. I admire what you have done and want you to know I appreciate it very much.

Thank you, Mr. Chairman.

Chairman **Miller**. I want to thank you also. I think that the purpose of this panel, and I think it was well served, was to try to demonstrate the extent to which alcohol can consume a family, and the stresses, turmoil, chaos and distress that can be created for the family when the chemicals get out of hand.

I think the other thing that is demonstrated is that with some support and some intervention, those cycles can be broken. Not that we will do it in a 100 percent of the cases, but there are programs that do work, support systems that do work for people who find themselves in the situation such as each one you have described.

Interestingly enough, you have described a situation where you basically didn't know what was happening to you. And because of outside intervention, as traumatic perhaps as an arrest, or an estrangement, or just silence but that some triggering event brought support and education to the family unit, and it seemed to work.

I guess one of the other things is the understanding here that being children and being parents is damn hard work. And sometimes a little guidance will go a long ways. The assumptions we make about the intelligence of our parents and intelligence of our children appear to be very often misplaced, in that we think we have the wherewithall to get through the next phase of life with no support systems.

I really appreciate your testimony. To those members of your families who aren't at the table with you, who came with you this morning and supported you and wished you well in your efforts to come here this morning and to continue on the journey you have started here, I really appreciate it. I think the whole committee—obviously you can tell by their comments, and hopefully a lot of the people who hear your stories, will find some of the same strength and support systems to help.

Thank you very much for your time and effort this morning.

Mr. **West**. Thank you.

Chairman **Miller**. The next panel that the committee will hear from will include Dr. Ian Macdonald, Administator of the Alcohol and Drug Abuse and Mental Health Administration of the Department of Health and Human Services; the Honorable Albert L. Kramer, presiding justice for Quincy District Court, Quincy, MA, and the Honorable Andy Devine, judge, Lucas County Court of Common Pleas, Juvenile Division, Toledo, OH.

If you gentlemen will come forward, please. Welcome to the committee. Your written statements will be included in the record in their entirety. To the extent you want to summarize, or comment, on some of the problems that have been earlier discussed, feel free to do so.

We will start with Dr. Macdonald.

STATEMENT OF DONALD IAN MACDONALD, M.D., ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. **Macdonald**. Thank you, Mr. Chairman. After the powerful testimony we have just heard, I am going to make just a few comments and then highlight my written statement. With your permission, I ask that my written statement be included in the record in its entirety.

A lot of what we do in the Federal Government seems to be to accumulate national statistics. I will just share some of those numbers with you. It was interesting that Mrs. Boggs recognized people from Louisiana have problems and you recognized that people from California have similar problems.

I would like to say to Mr. Coats I have traveled all over the country. I have been in Indiana. People in Indiana have problems, and people in Virginia and people in Michigan. In listening to the Wests, I was very conscious of the fact that the story I heard from young Mr. West, Bret, was very similar to what I heard in my own family. So what I heard wasn't new. I occasionally cried as Mr. West did.

When I look at the effects of problem drinking on the families of alcoholics, I see five general areas of concern. One concern is what alcohol does to society, as a whole. Families are a part of society—a survey we did in 1983 said the annual cost to society of alcohol problems in this country are at least $116.7 billion.

It costs money and that affects families. It affects crime. It affects abuse. It affects loads and loads of things. Society also affects us individually.

Mrs. West talked about the effects of the entertainment media. I worry about teachers who are chemically dependent. I worry about physicians who are chemically dependent. The parents have so much responsibility for a child and obviously have a major effect on them. There are 10 million or more adult alcoholics in this country, many raising children. Dr. Blume, who will be on the panel following this one will make the statement that one in every eight children in the country grows up in the home where an alcoholic is a problem.

The divorce rates in those families is seven times the normal rates. There are many ways that kids could have problems where alcohol is a problem in the home, from the very least, being embarrassed to take your friends home, or figuring out ways to keep your father from going to the school function so he won't be seen. There are also the more dramatic statistics—cirrhosis of the liver is the eighth leading cause of death in the country. We have heard from others—Mr. Lehman and others—about highway fatalities and the other major effects on the families that have been so eloquently presented.

We have also heard of the effects on parents where children are involved with alcohol. Our numbers say something over 3 million young people between the ages of 14 and 17 in this country have problems with alcohol. Their families suffer, and I can say that as a father of a 15-year-old who was on that track, that it is real suffering. These children upset their families; cause great family disfunction.

The fourth category I would talk about is while all of that is going on at the same time, the parents have problems. We heard that from the other witnesses—and I won't belabor the point. The agency I head is a Federal agency with three stated functions: functions of research, functions of transferring that research knowledge to practical use, and functions of serving as a national focus for strategies to deal with the problems of alcohol, drug abuse and mental health.

Research is where we receive most of our funding and that is where we spend most of our effort. In this area we are working on the fifth factor related to the family and to drugs and alcohol. That is the area of genetics. We are coming up with increasing evidence that there is a strong genetic predisposition for some people to develop alcoholism.

A twin study of a few years ago looked at alcoholic fathers and their sons. The study showed that when those sons who were twins and separated at birth were raised away from their alcoholic fathers, they were still four times more likely to develop the disease than children who were twins and did not have alcoholic parents. We are also studying the different chemistries that exist, such as alcohol dehydrogenization and, aldehyde dehydrogenization. We are also studying the electroencephalogram patterns of alcoholics and nonalcoholic. But it is fairly obvious that there is a genetic link at least in a fair percentage of alcoholism.

When young Mr. West was asked what would he tell his kids, I think with the history he had in his family I would tell my kids that they were taking a great risk drinking at all and would focus my efforts on convincing them that that was not a very healthy experiment. We are also looking at fetal alcohol syndrome. Dr. Blume, who I mentioned earlier, will talk more about that. We are concerned not only about the full effects of fetal alcohol syndrome, but with the other effects of alcohol consumption during pregnancy and if any level of consumption could be considered safe.

I think evidence would now say that until we have more data, you shouldn't touch alcohol during pregnancy. We are looking at protective effects of things like aspirin on alcohol consumption and its effects, and hopefully we will be coming up with more definitive data. In our intramural research program, we are looking at the relationship of aggression and alcohol use and the evidence showing alteration of brain chemicals, most particularly serotonin, in both of these disorders.

We have a grant announcement out now on children of alcoholics looking for the effects on children who grow up in homes where alcohol is a problem. We are also doing research on treatment. One of the things that I think we have to mention after hearing the previous personal histories is that we now realize treatment works. We weren't so aware of that a few years ago. There wasn't a whole lot of sense making the diagnosis of alcoholism if we didn't have anything to offer as effective treatment.

Now we realize we do. We, as an agency, are studying what is effective treatment, and what part the family plays. Another issue that comes to both the Congress and to me is the issue of treatment funding. We are involved in a joint demonstration project with HCFA, concerning which models of alcohol treatment work best. How much do they cost? How do you measure outcome? In the area of cost/benefit, I would cite a 1980 Blue Cross/Blue Shield study in Northern California which showed dramatic cost offsets in treating an alcoholic in the family.

What that study showed was that if you treated a person for his alcoholism, not only did his costs for general medical care drop, but so did the costs for the rest of his family. Obviously, this says what you have heard before, that when somebody is sick in the family, illness is also often present in other members. We are actively researching the effects of alcohol on women. As you may know, there is also a set-aside in the block grant this year for States to do more to expand treatment programs for women.

Our research budget is up 24 percent in that area, and continues to be a concern. In the area of knowledge transfer, it is my personal concern that physicians and others don't know as much about alcoholism as they should, and we are making efforts to remedy this situation. In November the National Institute on Alcohol Abuse and Alcoholism will be jointly sponsoring with the Betty Ford Center, the Annenberg Center, and AMERSA, a major conference to look at what we can do to enhance physicians' knowledge of alcohol problems.

We are planning a conference to look at the state-of-the art of knowledge concerning children of alcoholics. That will also be done later this year. We also have a National Clearinghouse for Alcohol Information which provides publications and audiovisual materials to professional groups and lay the public. As a point of national focus, I have been particularly interested in the many grass roots movements which have started and are underway. This is a great nationwide effort of concerned citizens.

We are joining them in providing support where we can. The First Lady, as you know, is involved with that effort, and Secretary Heckler has been involved with the teenage alcohol initiative. We have joined with groups like Mothers against Drunk Driving (MADD) and the National Federation of Parents and National Federation of Youth that are looking for our help and leadership. We have done a lot in the last 4 or 5 years. The situation it is not totally bad.

The 1984 High School Senior Survey showed that 5 percent of American high school seniors drink every day. That is a terrible number unless you compare it with the 9 percent who did so a couple years before. Our survey asked how many of those same young people had had five or more drinks on one occasion within the last 2 weeks. Forty percent said they did. When asked how many had had five or more drinks on three or more occasions within the last 2 weeks, 26 percent of the boys responded affirmatively. But the numbers in 1984 are down somewhat. They had been running 41 percent in 1983. Now, in 1984 it is 39 percent.

We believe that these surveys indicate that that is beginning to be an increased awareness among young people that alcohol is not a safe drug. When asked how many perceived binge drinking as dangerous, a still frighteningly low level of only 41 percent felt that it was dangerous, but that is better than the 37 percent rate of a couple of years ago.

Alcohol related highway fatalities are down. Also more people are being treated for alcohol problems. There is a lot going on, but I would join with all of the others today and say there is a lot more that needs to be done. I will be open for questions. Thank you.

Mrs. Boggs. Thank you so much, Dr. Macdonald. We are very pleased to have you here, and benefit from your testimony.

[Prepared statement of Donald Ian Macdonald, M.D., follows:]

Prepared Statement of Donald Ian Macdonald, M.D., Administrator, Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, Department of Health and Human Services

Mr. Chairman and members of the committee, thank you for the opportunity to appear here today to discuss alcohol abuse and its implications for the family.

Nearly 200 years ago, one of our country's most distinguished physicians, Dr. Benjamin Rush, labeled alcohol abuse an "addiction and a disease." He also provided the first epidemiological estimate of the number of deaths each year from alcohol abuse. His estimate of 4,000 deaths annually in a population of 6 million (66.7 per 100,000) is surprisingly close to present estimates (as high as 93.2 per 100,000).[1]

While problems associated with alcohol are still very much with us (and in many ways are exacerbated by the growing complexities of society and technology), we at the Alcohol, Drug Abuse, and Mental Health Administration [ADAMHA] take satisfaction in what has been achieved in the 15 years since the agency was established. The first edition of the "Special Report to the U.S. to the U.S. Congress on Alcohol and Health" (1971) referred to alcoholism as an "iceberg problem," because social pressures caused so many with the disease to deny it. In the years since, the hidden portion of that iceberg has become more and more exposed. There have been important shifts in our attitudes toward drinking. It is easier for alcoholics to admit having a disease than a defect of will. Organizations that previously stressed anonymity in their rehabilitation efforts have become more sympathetic to individual self-disclosure. Many of our leading citizens are now willing to acknowledge their own hard-fought battles with alcohol addiction. Their courage has made it easier for others to recognize that they too have alcohol problems—and to do so at an earlier age.

The use of alcohol, the most readily available psychoactive drug other than caffeine, is an issue which affects virtually every family in modern industrialized society. A recent Gallup Poll revealed that an overwhelming eight in ten Americans believe alcohol abuse is a major national problem. As many as one in three indicated that a drinking-related problem had caused trouble in his or her own family. One of the most disturbing findings in the study was the perception of alcohol-related family problems reported by young people. Among 18–24 year olds, fully 40 percent said that alcohol abuse has troubled their families. The figure for 25–29 years olds is 37 percent; for the 30–49 group, 35 percent; and for ages 50 and above, it is 26 percent.[2]

Today, an estimated 10 million adult Americans suffer from alcoholism and alcohol-related problems. In additions, an estimated 3.3 million teenagers between the ages of 14 and 17 are experiencing problems with the use of alcohol.[3]

Surveys show the average age at which young people begin drinking is 13, and that average age has been getting lower.[3] Eighty-seven percent of all 10-12th graders have tried alcohol.[4]

More senior high school students today use alcohol than any other psychoactive drug, with those who do often combining alcohol use with other drugs—with potentially deadly consequences. The proportion of high school seniors who report that in the prior two weeks they had taken five or more drinks in a row rose from 37 percent in 1975 to 41 percent in 1979. However, this figure has declined to 39 percent in 1984. Daily use of alcohol by high school seniors declined to 5 percent in 1984 (compared with the peak level of 7 percent in 1979).[5] Alcohol abuse and consumption are believed to be even higher among the high school students who drop out and are therefore not included in national surveys.[3]

These statistics indicate the extent of teenage drinking in America today. Yes, it is a problem worthy of special consideration. But, I must add, the news is not all bad. Today, young people recognize the health hazards associated with the consumption of alcohol and are taking action to reduce its toll. Local chapters of Students Against Driving Drunk are being established, hotlines set up, and non-alcoholic social events are planned by young people. Some of their awareness has been stimulated by government, but much of the grass root activity should be attributed to their own concern for a healthy lifestyle.

A similar desire for a better life can be seen in results of the 1983 survey of the membership of Alcoholics Anonymous. Membership in this self-help group increased by 37 percent from 1980 to 1983. The reported membership in 1983 was 653,000 (up from 170,000 reported members in 1968). The survey also shows that the proportion of members under age 30 has increased by one-third from 15 percent in 1980 to 20 percent in 1983. More people are recognizing alcohol problems, at a younger age, and are seeking help. The proportion of women in the total membership has remained stable at about 30 percent for several years, but is up from about 22 percent in 1968. Women, as well as men, find it easier to acknowledge an alcohol problem and seek local help earlier in their drinking career.[6]

The precise ways in which families are adversely affected by alcohol are more difficult to document. However, the rate of separation and divorce among alcoholics is seven times that of the general population, and two out of five domestic relations court cases involve alcohol.[1]

Few doubt that drinking plays a role in family violence and the abuse of spouses and children. Studies report that alcoholism or excessive drinking is involved in about half the cases of spouse abuse. Early reviews of child abuse have described associations between it and alcohol in as many as 38 percent of cases.[1]

Research is in progress in the intramural laboratories of the National Institute of Alcohol Abuse and Alcoholism [NIAAA] that will enable researchers to address the critical relationships between violence, impulsive behavior, and alcohol abuse. Intramural researchers have developed an extremely sensitive test that will allow direct and, thus, more precise measurement of a chemical found in human cerebrospinal fluid. Previous work has indicated this chemical is related both to violence and to alcoholism.

A 1983 review of the effects of parental alcoholism on children indicates that they are more likely to have school problems and to display antisocial behavior. Other studies report that such children have less self-esteem, more anxiety symptoms, more aggression, and more psychosomatic symptoms.[1] A variety of coping mechanisms seen in children of alcoholics have been identified-including those that suggest that some children may be very responsible and high-achieving adults relatively free of long-term psychopathology.[8] One study conducted to understand what factors spare certain children found that alcoholic families that maintained some predictable structures, particularly around the observance of family rituals (at meals, holidays, etc.), were less likely to produce alcoholic offspring than families with disrupted family rituals.[1]

In an effort to encourage and stimulate research in a wide range of scientific areas relating to children of alcoholics, NIAAA is preparing a special grant announcement, which will be issued shortly. In addition, NIAAA is planning to convene a consensus conference in 1986 on issues concerning children of alcoholics.

Another area of significance in alcohol abuse and its implications for the family is the psychological impact of children's alcohol or drug abuse or dependence. What effect does this have on the parents or siblings? These are areas faced daily by personnel involved in treatment of adolescent alcohol and drug abusers. Indeed, the prevalence of alcohol and drug abuse by young people has been a major factor in stimulating a reexamination of societal policies governing alcohol and drug use. Adolescent alcohol and drug problems have been described as epidemic, and specialized identification, treatment, and prevention programs have increased markedly in the past few years.

Concerned parents and others have banded together to change societal messages and practices which seemed to accept teenage drinking (and drunkeness) as a normal phase of adolescence. They have joined with their children and others to foster keg-free parties, alcohol-free graduation nights, etc. They have influenced laws and policies they see as fostering adolescent drug abuse and thereby threatening the lives of their children and stability of their families.

Mrs. Reagan has been actively involved with a grass root movement. The Department of Health and Human Services, through a Secretarial Initiative on Teenage Alcohol Abuse, has also sought to further stimulate and and facilitate these local efforts. The Initiative is a combined national effort by government and the private sector to address the issues relating to alcohol abuse among young people. As part of this initiative, two well attended National Conferences have been conducted. The most recent one, which was held last April, focused on the potential of the workplace as a site for the prevention of teenage alcohol abuse, especially drinking and driving. Hundreds of young people have been involved in preparing, attending, and carrying out Conference activities.

Other activities are now underway. In fiscal year 1986, for example, NIAAA will launch a major public education compaign directed at early adolescents and those who influence their lives—most significantly, their families. As part of this campaign, NIAAA will develop service materials and a variety of supportive print materials including a "Prevention Primer" for pre-teens, a booklet for parents describing ten ways to help children say "no" to alcohol and a teacher's manual—all in support of one another and to be used in conjunction with each other.

Further, State substance abuse agencies have been actively involved in assisting local groups of concerned persons to address these problems in their communities.

A recent calculation places the economic costs of alcohol abuse to the United States in 1983 at about $116.7 billion. The bulk of this amount—$89.1 billion—represents the value of lost productivity. The cost of various kinds of medical care for alcohol-related illness and injury totals $14.9 billion. The remaining $12.7 billion includes such added costs as traffic accidents, fires, crime, and other miscellaneous losses attributable to alcohol.[7]

Perhaps the highest cost is the incalculable pain and misery associated with alcohol abuse for the abusers, their families, and the larger society. There is no disagreement that those costs are profound.

We now recognize that alcohol abuse and alcoholism are both multidimensional with multiple causes. While many questions remain to be answered, we have made considerable progress in the field.

It is now generally accepted that three major factors enter into the development of alcoholism. In each case the relative weights of such factors may differ—sometimes markedly. These factors are genetic, developmental, and environmental.[8] In the meantime, let me share with you some of the major changes and accomplishments in the areas of alcohol abuse and alcoholism which have significant implications for the family.

It has been firmly established that a predisposition for alcoholism is inherited in some individuals. Studies of twins and adoptees have shown that sons of alcoholics are four times more likely to be alcoholic than sons of nonalcoholic fathers. A major breakthrough was reported recently when an NIAAA-supported research team identified two subtypes of alcoholism:

Environment-dependent, observed in both men and women

Environment-independent, observed in men only. The probability of its occurrence is increased ninefold if it is present in the father.

Clues are now emerging with respect to what exactly is inherited that makes an individual more susceptible.

Drinking during pregnancy is now known to pose risks for the health of the newborn. Programs directed toward women who have alcohol problems could sharply reduce the number of newborn who suffer such serious consequences of maternal drinking as the fetal alcohol syndrome and other alcohol-linked birth anomalies.[1]

To help prevent fetal alcohol syndrome and fetal alcohol effects, NIAAA will be working with a number of organizations including the Healthy Mothers, Healthy Babies Coalition (of which the Public Health Service is a part), the National Council on Alcoholism, the American Medical Association, and others; will develop materials for primary care practitioners and women; and will help other organizations in the development of FAS/FAE materials and programs based on the latest research findings.

The treatment of alcoholism has come of age. Once largely confined to dedicated members of groups like Alcoholics Anonymous and a few committed professionals, treatment efforts in recent years have grown tremendously. Treating alcoholics is now "respectable"—and training for physicians and others to treat the alcohol-dependent person reflects this new found status.[1]

There is an increased willingness to subject therapeutic efforts to research scrutiny—to determine what works best with whom and under what circumstances.[1]

Innovative employee assistance programs are now challenging the traditional belief that treatment must be completely voluntary to be successful. There is evidence that job-based referrals to treatment, provided early and in lieu of disciplinary action on the job, can be as effective as treatment sought on one's own.[1]

The fact that treating alcoholism within the framework of health insurance plans is cost effective has been demonstrated repeatedly.[1] And an NIAAA-sponsored study of 90 families with an alcoholic member who were enrolled with Blue Cross and Blue Shield of Northern California found that total medical care costs per family member (both inpatient and outpatient) decreased substantially over time after the alcoholic family member was admitted to an alcoholism treatment program. In fact, by the end of the study, inpatient costs per person per month of the alcoholic families were similar to those of a comparison group of families—and outpatient costs were actually lower.

There is a new public appreciation of the gravity of mixing drinking with driving. Citizens groups have been impressively effective in changing public attitudes toward drinking and driving, making individuals more aware of just how much alcohol impairs driving skills. The multiplication of very active and successful grass root organizations indicates that thousands of people across the country are willing to devote their time, energy, and/or money to the retesting of old approaches to alcohol problems and the development of new ones.[1]

These are just some of the changes which have taken place over the last one and a half decades. Without a doubt, each change has significant implications for the family.

Mr. Chairman, this concludes my formal statement. I would be pleased to answer any questions you may have.

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HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, DC, April 3, 1985.

DONALD IAN MACDONALD, M.D.
Alcohol, Drug Abuse, and Mental Health Administration,
Rockville, MD.

DEAR DR. MACDONALD: This is to express our personal appreciation for your appearance before the Select Committee on Children, Youth, and Families at our hearing, "Alcohol Abuse and Its Implications for Families," held here in Washington March 18. Your participation contributed greatly toward making the hearing a success.

The Committee is now in the process of preparing the transcript of the hearing for publication. It would be helpful if you would go over the enclosed copy of your testimony to make sure that it is accurate, and return it to us within three days with any necessary corrections.

Also, we would greatly appreciate your answering the following for the record:

1. What do we know about the cost effectiveness of (a) treatment approaches, and (b) prevention practices, in view of the enormous costs of alcohol abuse and its related problems?

2. During the hearing we heard testimony from a young mother who had to give up her children in order to complete her treatment for alcoholism at a residential treatment center. She indicated there seems to be considerable pressure to split a family up in order to take advantage of treatment and vocational rehabilitation. Is your agency aware of this treatment dilemma that apparently faces many mothers with a substance abuse problem? Can you share with us what is being done to address this problem at the federal level?

Let us again express our thanks, and that of the other members of the Select Committee for your testimony.

Sincerely,

GEORGE MILLER,
Chairman, Select Committee on Children, Youth, and Families.

WILLIAM LEHMAN,
Chairman, Task Force on Prevention Strategies.

LINDY (MRS. HALE) BOGGS,
Chairman, Task Force on Crisis Intervention.

1. What do we know about the cost effectiveness of (a) treatment approaches, and (b) prevention practices, in view of the enormous costs of alcohol abuse and its related problems.

Answer. Several studies have been conducted regarding the cost effectiveness of treatment approaches. Currently, the NIAAA is participating with the HCFA in developing and funding demonstrations of Medicare and Medicaid coverage for alcoholism treatment services in less costly settings. The project is in its fourth year of operation and evaluation of the activity is in progress. The final evaluation report is due December 1986.

Alcoholics and their families have been found to use a disproportionate amount of inpatient and outpatient medical services for a wide variety of physical problems related to excessive drinking. A major review of research conducted during the 1970s found surprising consistency across 12 studies. These studies indicated significant reductions in medical care use and expenditures related to various kinds of alcoholism treatment, amounting to a 40-percent median reduction in sick days and accident benefits. Additional studies since that time have confirmed this conclusion.

Other studies have found that total medical care costs per family member (both inpatient and outpatient) decreased substantially over time after the alcoholic family member was admitted to an alcoholism treatment program.

With regard to prevention practices, previous research efforts focused on measuring the impact of single variables to determine changes in behavior and often failed to demonstrate significant differences. A broader range of prevention approaches is now being tested, however, and evaluations are being designed to test models in which myriad factors and variables interact in contributing to alcohol-related problems.

Although definitive answers may not be forthcoming in the immediate future, research findings suggest that both educational approaches and laws and regulations contribute to a reduction of alcohol problems. For these to be effective, however, public support must be generated and sustained.

2. During the hearing we heard testimony from a young mother who had to give up her children in order to complete her treatment for alcoholism at a residential treatment center. She indicated there seems to be considerable pressure to split a family up in order to take advantage of treatment and vocational rehabilitation. Is your agency aware of this treatment dilemma that apparently faces many mothers with a substance abuse problem? Can you share with us what is being done to address this problem at the federal level?

Answer. I am distressed to learn that any program treating women for alcoholism would be unable to develop an individual treatment plan which could accommodate the presence of children. While it is true that in the case you cite, the fact that the woman needed to develop job skills to enable her to become financially independent at the same time she was gaining her sobriety made treatment planning more complex than it frequently is, such complexities are the challenge of adequate treatment programs. So central to treatment is the issue of spouse and child involvement that during the time when NIAAA directly funded alcohol treatment programs, guidelines for grant applicants required that the issue of the provision of child care services be addressed.

As you know, the responsibility for funding alcoholism treatment programs is now the responsibility of the states.

However, since our policies were developed in conjunction with the states, we have reason to believe that the states also agree with the need to involve the whole family in the treatment of alcohol misuse.

In addition, you should be aware that women are a research priority of the Institute and a number of studies are underway which should help us understand how alcohol uniquely affects women.

Mrs. BOGGS. We will now hear from Judge Albert L. Kramer from Quincy District Court in Quincy, MA. We are very pleased to have you here, Judge Kramer. We understand that you feel the single most important issue facing the courts today is alcohol abuse and its effect on families. We know we will benefit from your testimony.

STATEMENT OF HON. ALBERT L. KRAMER, PRESIDING JUSTICE, QUINCY DISTRICT COURT, QUINCY, MA

Judge KRAMER. Thank you. Let me thank you for your very kind invitation to appear before you and congratulate the committee for undertaking what I think is perhaps the most important issue confronting the courts: that of alcoholism and its effects on families.

I am of course aware that your committee has a much broader concern than the effects of alcoholism on the courts, but what I would suggest is that the experience of Judge Devine and other judges within the court system are only indicative of a much broader phenomenon that your witnesses have already begun to provide through testimony and that is basically when you are dealing with family violence or dysfunction you are to a large measure dealing with alcoholism. The staff at the Quincy Court over which I preside, the probation staff—have found that there is a large prevelance of alcohol in the cases coming before us. The staff is specially trained to detect cases involving alcoholism and where there is a reasonable suspicion of chemical abuse, the cases are referred for a clinical assessment.

From their assessments I can tell you that no matter at which legal door, no matter on which track the deviant behavior presented itself, whether by complaints of delinquency, child abuse, sexual abuse, domestic abuse or status offenses runaways or so-called stubborn children who were not obeying the commands of their parents we found in the vast majority of the cases underlying the problems of alcoholism with devastating effects on the families, similar to the examples you heard today.

Let me share some statistics, if I may. Between January 1980 and December 1984, our court heard 139 cases of child abuse affecting about 222 children. We did a study of every single one of those cases. What we found: such as in the cases you have heard for example, Beverly's—42 percent of the abused children had an alcoholic mother and 34 percent an alcoholic father.

So we found that in a vast majority of the cases where the kids were abused, they had in their homes an alcoholic parent and in many cases two alcoholic parents.

I can tell you that I have personally heard over 1,000 cases in my 10 years as a judge of so-called domestic abuse, where a spouse or family member has come to court after being abused seeking protective orders. I can recite a lot of anecdotal cases but your examples here are powerful ones from which you can take note. Instead what I would like to do is cite some findings we have made that will indicate to you that what you have heard from the witnesses today are not just anecdotal stories, but are clearly representative of a pattern which is in our court system, and I suggest, in the population outside our court system.

Between April 1, 1983 and June 30, 1984, we conducted a preliminary study of victims of domestic abuse coming before the court. We began to detect a large number of cases involving alcoholism. We interviewed the abusers (as well as victims) and found that 61 of the 75 abusers, 81 percent, had a problem with alcohol. I am not saying they were merely under the influence of alcohol at the time of the aggression and the abuse. I am saying that by clincal assessments and social histories and all the rest, we were able to ascertain that 81 percent were alcohol abusers.

What was even more interesting is looking at the victim. Oh, may I note one other fact? Out of 61 abusers who were suffering from alcoholism 88 percent of them (or 54 of those 61) came from families of alcoholics. So we found that 8 out of 10 of all the abusers were alcoholics and 9 out of 10 of them came from families of alcoholics.

We looked at the victims. Twenty-four percent of the victims themselves had abused alcohol. But even more interesting was that 40 of 75 victims, 53 percent, came from families of alcoholics. It was very very clear what we were seeing. We were seeing victims who grew up in alcoholics families, who had lost their coping skills, like Marjorie began to believe being abused was a way of life and began to many or enter relationships with little choice or understanding of choice to get away from an abusing situation.

We are currently seeking a controlled study of domestic abuse cases in order to study them in more detail, but what we have found certainly suggests that Dr. Macdonald's work in this area is quite important in terms of implications for programs and strategies.

We found similar patterns with sexual abuse and runaways. Our delinquency studies were consistent with many of them including the recent 1984 study which was done in the 250-bed secure facility for juveniles in Brookshire Farm Center in New York where they found 60 percent in placement had alcohol problems. In addition, 50 percent of those in placement came from homes with an alcoholic parent. We were looking at children of alcoholics.

Even before the children began to drink they were reflecting the dysfunction and mirroring the problems in families from which they came. Three times as many children of alcoholics are in foster care. Two times as many are runaways.

The more recent national studies show that a disproportionate number of alcoholics are vulnerable to sexual abuse and suicide, I know we are talking about correlations and we are not talking about causes. I realize that in addition to the alcoholism that we find in court, there is a large degree of sociopathic behavior. But the point I wish to make is whether the sociopathy is causing the alcoholism, or the alcoholism is causing the sociopathic behavior, the fact is that we must essentially and primarily deal with the alcoholism first if we are going to try to deal with these problems. We must primarily treat the alcoholism before we start treating the underlying psychological and the social problems with conventional therapy. I suggest that conventional forms of therapy are generally doomed to fail while the alcoholic is still actively drinking and very much involved in denial and thereby resistant to treatment.

Yet, I am alarmed to tell you, as I am sure you are finding out, that throughout this country conventional therapy is primarily being used in child abuse cases in treating the alcoholic abusers as well as in similar sexual abuse and domestic abuse cases. And one of the persons who came before you today said "they didn't even ask about my drinking."

I can suggest to you that these cases involving alcoholism not only get by doctors, but the courts, probation departments and therapy counselors, as well, without, their even asking about the alcohol, as they proceed to make referrals to conventional therapy.

Yet, we are——

Chairman **Miller**. When you say "conventional therapy," you mean what?

Judge **Kramer**. Instead of utilizing AA or Al-Anon or appropriate alcohol counseling and self-help groups for grownup children of alcoholics to deal with past crippling family dysfunctions, conventional once-a-week counseling sessions are employed which do not even begin to focus on the underlying and serious issues of alcoholism.

I would suggest that it takes quite a bit of time after people stop drinking—and that should be the effort initially—that they can begin to deal with the underlying psychological problems.

That is why AA is underused, Al-Anon is underused, and some of these self-help programs that are far more successful are underused because, I believe, of this bias which exists in the therapeutic world.

I would suggest the need for new sentencing and dispositional strategies in the courts and new treatment priorities for rehabilitation.

I would suggest to your Honorable Committee that these new strategies and priorities center around three basic recommendations that I would make.

One, I suggest that it is vital to sensitize the courts, probation departments and the entire treatment community to the epidemic proportions to which alcohol abuse is present in the cases that present themselves.

Two, that it becomes vital to educate all these groups to understand the extent to which the alcoholic member disrupts the emotional stability of the entire family and convince them of the need to first treat the alcoholic and, if necessary, the entire family, the nondrinking spouse, so-called co-alcoholic, and children who are at risk as well.

At the Quincy court, we have begun to do some of these, and let me share briefly a few efforts to give you examples of what I believe can bring about results.

With respect to domestic abuse, we have attempted not to let cases like Marjorie's go by.

With 80 percent of the abused victims having an alcoholic partner, and with 55 percent of the victims being from alcoholic families, and 80 percent of the abusers coming from alcoholic families, Quincy court requires an assessment and counseling session with every single victim of abuse to help empower those victims to understand that they have a choice, that it is not their fault, that they need not submit as they did in the past to an alcoholic parent, or to an alcoholic partner, and to let them know that part of their abusive experience that is now occurring, even if they don't drink, may well have resulted from their upbringing with alcoholism in the home and the abuse that they have become accustomed to accept.

When appropriate victims are referred to Al-Anon, which, as you know, has a philosophy that one has choice, and to other programs which counsel grownup children of alcoholics. Unfortunately, this approach is not utilized throughout the court system generally.

Second, with child abuse and such cases, we take the vital signs. The analogy might be that when somebody comes to see a doctor with a pain or sore throat, one always take the temperature and blood pressure because we want to check the vital signs.

If we know that 50 percent of the runaways are reported by parents who themselves may suffer from alcoholism, shouldn't we ask in every case whether there is drinking going on in the home? Shouldn't we determine if there is alcoholism in the family from which the child is running away? Perhaps the act of running away is a healthy reaction to an abusive home and the child should not be forced back as a runaway into a very destructive environment without some form of intervention with the family.

Shouldn't we, in all child abuse cases, even though the presenting problem may be physical abuse, see if alcoholism is present just as we should look to see if sexual abuse is there? Shouldn't we always be on the lookout to detect the high volume of cases involving alcohol abuse so that we might refer the child of an alcoholic, at risk, into a program to deal with the family dysfunction or the co-alcoholic to deal with his or her problems and the alcoholic to undergo treatment?

Also, I would recommend, in addition to total family treatment, is that the treatment be intensive and tightly monitored, and where we have clout, to make it mandatory.

For instance, where we have a juvenile committing a crime, or a parent who seeks to regain custody of a child or a parent who is accused of child abuse and perhaps a criminal act, where we have probation or something hanging over their heads; my suggestion is that the treatment program for the alcoholism cannot be once-a-week counseling. The program has to be—because we are dealing largely with problem drinkers—it has to be intensive.

I suggest a model such as our program of a 30-week duration involving a counseling session and three AA meetings a week, that is 120 treatment episodes in the course of half a year.

You can't get somebody to stop drinking with a once-a-week counseling session. The program must be intensive.

I noticed that Bret said, "My arm was twisted somewhat." I call that approach "the Al Capone philosophy." Some of you may remember him, although he is not the greatest role model to follow. He said, "You can get a lot more done with a kind word and a gun than a kind word alone."

My suggestion is that when you are dealing with high-denial alcoholics, many of whom have not confronted the disease, it becomes vital to put them in highly monitored programs and use what I call tourniquet approaches.

In Quincy, if an offender is convicted of driving under the influence and fails to comply with the alcohol program, we may commit him to jail for a couple days and bring him back out and ask if he wishes to go into treatment or face further incarceration. We must force and compel treatment with high-denial alcoholic offenders.

I understand people in the community will say that unless somebody comes with a recognition of the disease, unless they come to treatment voluntarily, that treatment is doomed to failure. I suggest that may be true with psychological disturbances but it is totally untrue with chemical dependency.

All the research demonstrates that individuals who are compelled in some way—when a doctor tells them they are going to die unless they stop drinking or a spouse tells them they are going to leave unless they stop, or a judge says they are going to jail unless they stop, unless they are confronted in some way to deal with the alcoholism, unless they reached that bottom by themselves and that high degree of pain—they will not stop. But they will if this pressure is applied. We must begin to learn that coerced intensive treatment can work in a judicial system.

I notice that Representative Lehman was interested in drunk driving cases, and may I add that in the Quincy Court, we began a program for every single first offender convicted of driving under the influence, and I admit to feelings of chagrin to have to state to you that we have the highest number of drunk-driving cases in the State, over 1,200 a year.

We began to realize that the first offender was not an overindulging social drinker. We began to give 1st offenders 2-day alcohol assessments—looked at the family social history, psychological testing, like the McAndrews, Mortimer Philkins and MAST tests. We interviewed family members and reviewed the criminal records. Clinicians making reliable assessments found that 80 percent of all first offenders were indeed dependent. They were not just unlucky persons, who happened to get caught on a night out.

We realized this was not unusual because it takes between 200 to 2,000 times to be on the road drunk before one is picked up, depending on the aggressiveness of the police. This is an actual study. So the odds were that one had to drive drunk almost three or four days a week every day of the week for several years to be picked up once. So "there but for the grace of God go I," is a myth. Overindulging social drinkers, by and large, are not the ones being arrested to appear before the court.

For most 1st offenders, rather than assigning them to the ASAP program (based on the idea they were just social drinkers and once a week of alcohol education for 8 weeks would be enough), we instead, we put them through 30 weeks of three AA meetings and a counseling session, all monitored, holding the so-called tourniquet sentencing over their head.

I can tell you we have kept 60 percent in treatment for 30 weeks with sobriety as a result of that. We have lost 40 percent. That is not a bad record when you are dealing with serious records in alcoholism.

I would strongly suggest that this approach be looked at and I would be glad to forward the results of that study analyzing the results of this behavior.

[The information follows:]

FURTHER TESTIMONY REGARDING DRUNK DRIVING BY ALBERT L. KRAMER, PRESIDING JUSTICE, QUINCY DISTRICT COURT, MASSACHUSETTS

Mr. Chairman and members of your distinguished committee: It's clear why drunk driving heads the criminal justice agenda in Massachusetts and across the Nation. Annually, there are 26,000 highway fatalities, over half a million injuries and literally billions of dollars expended in medical costs and automobile insurance, as a result of drunk driving.

In terms of burdening the court, one out of every five arraignments in the Commonwealth of Massachusetts is an OUI (Operating Under the Influence) case. If we discount complaints like driving to endanger and red light violations, that accompany OUI complaints, drunk driving actually accounts for 25 percent of all arraignments.

If we need further justification for prioritizing drunk driving as a public issue, I call your attention to the study conducted by the Massachusetts Commissioner of Probation showing that OUI offenders are just as destructive off the road. Forty percent of them were found to have prior criminal records involving offenses such as disorderly conduct, larceny, assault and battery, etc. In fact OUI offenders are heavily involved in crimes across the board. Fifty percent of all violent crimes, 65 percent of all homicides, 50 to 60 percent of all child abuse, and 70 to 80 percent of all domestic abuse cases are committed by offenders who are intoxicated—and a fair number of these have an OUI conviction on their record.

What I am suggesting, and what I intend to document, is that when we're dealing with drunk drivers, we're not dealing with social drinkers who happen to overindulge. Contrary to this general misconception, we are essentially dealing with alcoholics.

If we're going to explore more effective approaches to combat drunk driving, I think it's vital that we put an end to some of the underlying misconceptions upon which many existing policies lie. Judges must come to realize that the OUI population is not comprised of social drinkers who had "a little too much to drink." The often quoted remark, "There but for the grace of God, go I" is basically a myth.

Sure social drinkers overindulge and on occasion drive drunk—but they don't often get arrested. The research shows that there is an extremely low probability of being arrested while driving drunk on the road. Statistically, a driver would have to commit somewhere between 200 and 2,000 drunk driving violations to be picked up just once. The odds are great that the vast majority being arrested are alcoholics on the road, drunk, three or four times a week, and driving for several years before being caught. The Quincy Court conducted 2 day clinical evaluations of all OUI offenders coming before it consisting of personal interviews, psycho/social histories, a battery of personality and chemical dependence tests for alcoholism (M.A.S.T., C.A.G.E., M.M.P.I., Mortimer Filkins, McAndrews, etc.), blood and urine analysis, interviews with family members, and observations of the offender during participation in group discussions. Our latest evaluations from June 1, 1984 to March 15, 1985, of 365 first offenders revealed that 83 percent (304) of them were alcoholics or problem drinkers and only 17 percent (61) were social drinkers.

Clearly the Alcohol Safety Action Program model, currently utilized here in Massachusetts and in most States throughout the country, consisting of only 16 hours of education, is totally ineffective for such a population. Judges must engage in sentencing and treatment strategies geared for alcoholics, not social drinkers.

In 1979, Quincy Court began to do just that. Beginning with second offenders, the court began to impose a 90 day House of Corrections sentence, with 14 days to be served in jail and the balance suspended, with 1 year probation. (When the new drunk driving law was passed, Rutland, a 14 day inpatient program, run by the State, was used in lieu of jail). As a condition of that probation, the offender had to enter a 5 day-a-week, tightly monitored alcoholic counseling and Alcoholics Anonymous, (A.A.) program, for 30 consecutive weeks.

We encouraged the establishment of the Eastern Massachusetts Alcohol Program [EMAAP] to assist in this effort. The offender pays $400 to this private treatment program for counseling and for monitoring the attendance of all A.A. meetings.

It is a form of coerced, intensive and monitored treatment. If offenders fail to comply, they are immediately brought back to the court and given a series of weekend sentences. After the first weekend is served, they are told if they attend their A.A. meetings, the court will stay the execution of the remaining sentence and they do not have to report to jail the next weekend. However, if they fail again, they will have to serve the remaining weekends. We were relying on jail as a motivator, and on a program of long-term A.A. involvement for recovery.

That leads to the question as to whether treatment can be coerced. Many professionals in the therapeutic community claim that treatment only works for those who come to it voluntarily. I suggest that too is a myth. I believe that current research bears me out. Our own experience is that if the court threatens or sentences offenders to jail, it motivates more of them to enter and stay in treatment.

Of course, the program does not work for everyone. The fallout rate is high, we estimate about 33 percent. But getting 67 percent of alcoholics through a 30-week program, a good number with sobriety, is a fairly good result. I mention sobriety, for our goal is not to achieve controlled drinking. We mandate abstinence. Every reliable study indicates that abstinence is the best treatment goal for alcoholics.

Next we expanded this approach to first offenders. Our evaluations revealed that over 80 percent of all our first offenders were alcoholics or high risk drinkers. So in 1981, we imposed, a weekend sentence for all first offenders—a shock sentence, with treatment to follow. Well, every offender appealed to the jury court that had a more lenient policy, so after a year, we finally settled on a compromise. We sentenced first offenders to confinement at a treatment center for a 2-day assessment, during weekends. After assessment, offenders would be placed into one of three categories: social drinker; early to mid-stage alcoholic; or mid to late-stage alcoholic. As a result of the assessments, 74 percent were placed in the last two groups.

If an offender were assessed as a social drinker, he or she was assigned to a conventional ASAP education program. If not, he or she had to attend a 30-week program of one counseling session and three monitored A.A. meetings per week. If an offender obtained a family member to be involved, who would go to Al-Anon and the counseling sessions, the program length was reduced to 20 weeks. The strategy followed research findings that when a family member is involved, there is a much better opportunity for success.

We approached our State's Divsion of Alcoholism and gained approval to experiment with this 30-week program. Two agencies were contracted to provide treatment services and we now have in place a hole new concept and approach for dealing with 1st offender drunk drivers. We believe we are achieving significant results but we await an objective evaluation now underway to test the program's effectiveness over a period of time.

Let me conclude by saying that our experience dictates that a new sentencing approach between the courts and treatment community must be developed. In attempting to do so, it is vital that we understand some of the guiding principles which have emerged to date.

First, we must recognize, as a fact, that we are not dealing with a group of people, who happen to be nice, middle class social drinkers. We are dealing mostly with alcoholics and high risk drinkers who get into very serious trouble and need to be apprehended, assessed, and in most cases compelled to enter into intensive and tightly monitored treatment.

Second, we must incapacitate the more serious offenders, even though they remain in the community. In many cases this can be done by restricting their opportunity to drink—placing them under house arrest i.e. confined to their house at night by means of a curfew, until such time as they have gotten significantly involved in the A.A. Program. If the offender is not working, we would require community service at detox centers to occupy his or her days. All of these have worked well in Quincy.

Third, we need to experiment with pre-trial release—with mandatory A.A. attendance and a requirement of turning in one's license, pending trial. The same principle applies to convicted offenders awaiting treatment at Rutland. They should be required to enter treatment immediately upon their conviction.

Fourth, of course, we need more inpatient programs like Rutland to avoid excessive waiting periods.

Fifth, it is essential that mandatory aftercare treatment be made as a condition of probation in every case after an offender is released from Rutland, any inpatient program or jail.

Finally, we should strongly encourage judges and probation departments to tightly monitor and surrender offenders on probation, the instant they detect a failure to comply with court ordered treatment. Surrenders should not await a further offense. Without sanctions, the treatment has little chance of succeeding in most cases.

Let met leave you with one last thought. A forum of this type provides us with the rare opportunity to review our past efforts and map our future course to effectively deal with drunk driving and all its destructiveness. My hope is that "a consensus for future action" can emerge as an agenda for legislative, executive, and judicial action.

Additional Testimony Regarding the Ratio of Serious Problem Drinkers to Social Drinkers by Albert L. Kramer, Presiding Justice, Quincy District Court, Massachusetts

Mr. Chairman and members of your distinguished committee: At your request I am providing for the record additional statistics regarding the ratio of serious problem drinkers to social drinkers based on our assessment of 1st offenders convicted for operating under the influence. I have already submitted statistics for the recent period from June 1, 1984 to present showing that 83 percent of the first offenders were alcoholics or problem drinkers and only 17 percent were social drinkers. Let me provide you with the statistics since the inception of the program from November 1982 to present, those evaluations show similar results. Out of 1,252 1st offenders, 82 percent (1,031) of them were alcoholics or problem drinkers and only 18 percent (221) where social drinkers.

These statistics are consistent with the attached assessment by the state of Pennsylvania for the year 1983. The attached statistical summary show that out of 1,935 individuals convicted for operating under the influence in Pennsylvania 51.75 percent were severe problem drinkers, 26.03 percent were moderate problem drinkers, for a total of 78 percent, and only 22 percent were social drinkers.

I hope that these statistics are of further assistance to you.

ALCOHOL HIGHWAY SAFETY RELATED DATA FOR PENNSYLVANIA, MONTH TO DEC.—YEAR TO 1983, JANUARY 11, 1984

Date item	Month to Dec. 31	Month to Dec. %	Year to Dec. 1983	Year to Dec. %	Incp. to Dec. 1983	Incp. to Dec. %	Deletes
Profile Code:							
Social drinker	170	8.79	4,041	20.05	9,046	22.21	6
Moderate problem drinker	671	34.68	5,253	26.07	10,602	26.03	4
Severe problem drinker	1,094	56.54	10,856	53.87	21,075	51.75	15
Language problem	0	0	0	0	0	0	0
Too incoherent to complete	0	0	1	0	1	0	0
Drug profile	0	0	0	0	0	0	0
Total	1,935	100.0	20,151	100.0	40,724	100.0	25
Blood alcohol at time of arrest [BAC]:							
0.20 and above	515	26.61	5,572	27.65	11,473	28.17	1
0.15 to 0.19	664	34.32	6,901	34.25	13,620	33.44	11
0.10 to 0.14	469	24.24	4,546	22.56	8,776	21.55	7
Below 0.10	44	2.27	439	2.18	1,050	2.58	1
Unknown	243	12.56	2,693	13.36	5,805	14.25	5
Total	1,935	100.00	20,151	100.00	40,724	100.00	25
Average BAC	17		17		17		
Refusals	185		1,951		3,927		
Multiple drug use:							
Amphetamines	80	10.39	757	9.12	1,435	8.34	1
Antidepressants	3	.39	96	1.16	219	1.27	0
Antabuse	22	2.86	244	2.94	461	2.68	1
Barbiturates	49	6.36	377	4.54	772	4.48	0
Cocaine	44	5.71	391	4.71	755	4.39	0
Marijuana	278	36.10	3,095	37.30	5,848	33.97	2
Opiates	8	1.04	89	1.07	201	1.17	0
Tranquilizers	78	10.13	876	10.56	1,794	10.42	0
Others	208	27.01	2,373	28.60	5,730	33.28	5
Total	770	100.00	8,298	100.00	17,215	100.00	9
Persons using 1 drug	383		4,708		9,983		
Persons using 2 drugs	105		980		2,032		
Persons using more than 2 drugs	48		461		888		
Total	536		6,149		12,903		

Judge KRAMER. Let me conclude basically by saying that I appreciate the opportunity to appear before this committee. Its work is important.

I believe you can make a difference because I believe you can give validity to an undeniable but yet-to-be-accepted fact, that alcoholism is the primary factor in family violence and dysfunction; and second, that special treatment for the alcoholic and all members of the family at risk is an essential first step to recover family stability and hopefully restore a better quality of life.

Thank you.

Chairman **MILLER**. Thank you.

[Statement of Hon. Albert L. Kramer follows:]

PREPARED STATEMENT OF HON. ALBERT L. KRAMER

Mr. Chairman and distinguished members of your honorable committee:

I want to congratulate your committee for undertaking what in my opinion is the single most important issue facing the courts today: alcohol abuse and its effect on families. I realize that the committee's concerns are broader than the judicial system, but I believe that our day-to-day experiences in the courts are merely illustrative of a more general phenomenon to what many of your witnesses with different perspectives will give credence—that is "when we're dealing with family violence of dysfunction, in large measure, we are dealing with alcoholism."

The Quincy District Court, over which I preside, has specially trained its probation staff to detect cases where there is a reasonable suspicion of alcohol abuse and make referrals for alcohol evaluations. Through clinical assessments and our own studies, we found that it made no difference which legal door the deviant behavior presented itself, whether by complaint for juvenile delinquency, child abuse, spousal abuse, sexual abuse, or even status offenses, such as truancy, runaways, or so called stubborn children, in most cases, we were essentially dealing with an underlying problem of alcoholism, with devasting effects on the entire family.

Let me share some statistics. Between January 1980 and December 1984, the Quincy Court heard 139 cases of child abuse involving 222 children. A study of those cases showed that 42 percent of the abused children had mothers who were alcohol or drug dependent and 34 percent had fathers, similarly addicted. It was clear that it the vast majority of the 139 cases, the abused children had at least one parent who was an alcoholic and in many cases, both parents.

I personally have heard over one thousand cases where a spouse or family member has sought protective orders, after being abused. I can relate many anecdotal incidents, but I prefer to cite some findings based on a preliminary survey of 75 victims who were personally interviewed between April and June 1984. The study revealed that 81 percent of the abusers were alcoholics and 54 percent of those alcoholics came from alcoholic families. It also revealed that 24 percent of the victims were alcohol abusers and 53 percent of all 75 victims, themselves grew up in alcoholic families. The implications are obvious and we are now undertaking a controlled study to carefully examine the connection of alcoholism with this court population, the results of which 2 shall be glad to share with your committee upon the study's completion.

We have also found similar patterns of alcohol addiction in cases of sexual abuse and runaways.

In delinquency cases, our findings are consistent with many other studies including one done in 1984 at the 250 bed secure facility for juveniles at the Berkshire Farm Center for Youth in New Canon, New York. The study found that 60 percent of those in placement were alcohol/drug abusers and 55 percent of those in placement came from homes with alcoholic parents.

While there is a high level of abusive drinking among the kids that come to court, many of the youngsters mirror family problems and reflect family dysfunction, even before they start drinking. The low self-esteem of children of alcoholics is dramatized in almost every study. Three times as many children of alcoholics are placed in foster care; two times as many children of alcoholics run away from home, and a disproportionate number of these children are more vulnerable to sexual abuse and suicide.

I do not wish to appear myopic. I am of course aware that we are talking about correlations and not necessarily causes and that along with the alcoholism, there is a great deal of sociopathic behavior. However, whether sociopathy causes the alcoholism, or vice versa, it is clear that the alcoholism must be the primary concern in considering treatment. Before we can even begin to think of treating some of the underlying psychological and social problems that are in addition to the alcoholism, we must first stop the drinking and treat the family dysfunction around the alcoholism. If not experience, common sense tells us that attempts to treat the psychological problems of the alcoholic with conventional therapy is doomed to fail while the alcoholic is actively drinking, and refusing treatment. Unfortunately, that is the treatment of choice followed today throughout the country, with its resultant exorbitant cost in money and human misery.

It is clear that in the courts, we will need new sentencing and dispositional policies and in the vast rehabilitation network, we will need new treatment strategies. Both of these must center around:

(1) Sensitizing the court, its probation departments and the entire treatment community to the epidemic proportions to which alcohol abuse is prevalent in the cases that present themselves;

(2) educating them to understand the extent to which an alcoholic member disrupts the emotional stability of the entire family, and

(3) convincing all of them of the need to first treat the alcoholic and the entire family—the nondrinking spouse and children, as well, if that be the case.

At the Quincy Court, we have begun to do just that. The victims of domestic abuse, 80 percent of whom are women who have been abused by an alcoholic spouse or partner, are referred to Al-Anon and special alcohol counseling. We understand that many of them do not have drinking problems but they did grow up in alcoholic homes. They are in need of support and counseling to learn that they have worth, that they are not at fault, and that they do have choice and need not submit to an abusive alcoholic parent or boyfriend. In these cases merely pressing the abuser into treatment is not enough.

We at the court have come to understand that while the parent may report a child as a runaway or charge him or her as a stubborn child, we must check to see if the child is running away from or reacting to an alcoholic parent. If so, the child at risk is referred for special counseling to deal with the alcoholism in the family and the parent is pressed to undergo alcohol treatment. If the parent refuses such treatment, instead of forcing the runaway back to his home, a Care and Protection proceeding is instituted to remove the child from this destructive environment and he or she is placed into foster care.

We utilize alcohol assessments for all delinquency offenders and child abuse victims, where there is any indication of the presence of alcohol abuse and appropriate treatment is ordered.

For the alcoholic, the treatment is not optional, in cases where we have control. It is mandatory. It is also intensive. Counseling and at least three A.A. meetings a week, for a 30-week duration, is ordered and tightly monitored. The results have been most heartening.

I appreciate the opportunity to appear before this committee. It's work is most important. This committee can make a major difference. It can give validity to an undeniable—but yet to be a generally accepted fact—that alcoholism is a primary factor in family violence and dysfunction and secondly, that special treatment for the alcoholic and all members of the family at risk, is an essential first step to restore family stability and hopefully restore a better quality of life.

Chairman MILLER. The Honorable Andy Devine.

STATEMENT OF HON. ANDY DEVINE, JUDGE, LUCAS COUNTY COURT OF COMMON PLEAS, JUVENILE DIVISION, TOLEDO, OH

Judge DEVINE. Thank you, Mr. Chairman.

Thank you, Mr. Chairman and members of the select committee. My name is Andy Devine. If you wonder how I got my name, you are right; it was not given to me by my parents but by my peers who changed my name, and it stuck—to show you the power of peer pressure.

For the past 10 years, I have served as juvenile court judge of Toledo, Lucas County, OH. Prior to that, I served as State legislator, county commissioner, Toledo City councilman and municipal court judge.

I am also presently serving as chairman of the Alcohol/Substance Abuse Committee of the National Council of Juvenile and Family Court Judges.

The National Council of Juvenile and Family Court Judges is the oldest judge's association in America. It was founded in 1937 and is presently centered on the campus of the University of Nevada, Reno. I wish to send special greetings from our National Council to—although I don't see her here—to Congresswoman Vucanovich and also to Congressman Levine.

We started getting along in Ohio and Michigan long ago except on any given Saturday in November, and then it is open warfare, but I heard his name mentioned many times on WJR and I appreciate the good work he has been doing in this body.

Although this paper does not bear the imprimatur of our national council—I did not have time to run it by the governing board—I believe it fairly well reflects the philosophy of the juvenile court judges across the country.

The population of Toledo, Lucas County, is approximately 500,000. The juvenile court has 202 employees. I am the only judge, but I have 11 referees, and they hear cases and they are covering my cases today. Our budget in 1984 was in excess of $4,000,000.

The court heard 15,520 cases, the largest categories being delinquency, traffic, dependency/neglect, paternity during 1984.

You can read my speech. I would much rather share with you what we are doing in Toledo.

Chairman **Miller**. We would appreciate that.

Judge **Devine**. I am reminded as I take on this task of the experience I had when I first ran for the legislature, which I am sure you have had. The League of Women Voters wanted to know my qualifications to see if I could sit as a legislator, and so they sent out many questions. One was, what do you perceive to be the problems in the field of education in the State of Ohio, and how do you propose to solve them, in 50 words or less.

I can't begin to share with you the magnitude of this problem and all the things we have attempted to do in our area to address it. It is a terribly complex subject.

Let me tell you briefly what we have attempted to do and you can take it from there.

Three years ago, this awareness of this problem came to my attention. I knew for years that it was a problem, but I always felt it was always somebody else's problem, not mine.

But there was nothing else happening. There was nothing happening in the community. There was almost a total denial in the community. The schools were denying it. The court was denying it. Everybody was denying it.

We didn't have a single treatment on facilities for kids in Lucas County. I was sending them to Minneapolis, Pennsylvania, New York, all over the State, but we had nothing in our own community.

Then the problem of trying to work with those kids, only to find that sending them out of the community, you couldn't work with child and family, which we found to be essential.

So, what I did was I called about seven people to my office and sat down with them and said, "Hey, we've got a problem; let's do something about it." The response was tremendous, right from the beginning. Everybody said, "God, let's do something."

That committee grew very quickly from 7 to 14 to 20 to 40. Now, the question became, what are we going to do?

Having had some experience of fundraising, I went out to industry and got some money and 14 of us went up to Minneapolis—that was considered to be kind of the most informed community in the country on dealing with these problems.

We spent 3 days up there. Two things happened on that trip. One, we not only got a lot of useful information, but more importantly, the 14 was a cross section of the community—mental health, hospital, court people, school people, parents, PTA, you name it.

For the first time, we began to dialog with one another, to share with one another and trust one another as a group. It never happened before in the community.

We came back, took another trip to Cincinnati. We came on three basic simple concepts that we decided would be our game plan.

One, it had to be a total community commitment. There is no way that any one family, or any one agency, or any one department, or any one school was going to solve this problem. We had to work together as a team. And we would have to hold together in the community.

Two, the family was the center of all our activity. If we were going to affect the lives of children and leave them in the home, we better make sure the home is in place—family, children, that's it.

I paint the picture of a wheel. First we thought the family was a spoke. We found out the family is more important than the spoke. The family is the hub. Everybody else is the spoke; the court, schools, mental health, everybody else is there to support family and deal with family and give the family the tools to do the job to take care of their children.

In addition, the court played an additional role which was rather unique because of the power and prestige of the court and the way this started. The court played the role of the rim in addition to a spoke.

The court used its power and prestige to keep these disciplines in place, to keep them supporting family, to hold them somewhat accountable as you can, not having direct jurisdiction over them, but indirectly you do have, the juvenile court judge has a lot of jurisdiction over these agencies to provide that the support system is there.

The third thing we decided was that there was no short, simple solutions. It was going to be around for years. We were going to have to stay together for years to deal with this problem. It was that complex and that ingrained in our society that there was no pill that we were going to find that was going to make this problem go away. So, we were going to have to hang in there for years.

We have been working together now for 3 years and in my opinion the excitement, the results have absolutely been phenomenal in our community. It is one of the reasons I was appointed as chairman of our National Council because it made so much sense that the judge should play this kind of a role in the community, for our juvenile court judges across the country. That is one of our goals.

But you come to our community and you share with the superintendent of the schools, you share with the police department, you share with the hospitals, you share with the parents, you share with anyone in our community and the one thing they will tell you is that it has a beautiful relationship, everything works together.

The court is supporting the hospitals, as Judge Kramer says, getting the kids into treatment and make sure they get treatment, and while they are there, we are supporting families to make sure that the families are a part of that.

I have jurisdiction not only over the child but over the parents, and if the parents don't voluntarily join Parents Helping Parents, which is one of our most effective support groups in the community—perhaps the most effective support group in the community, Parents Helping Parents—I order them to go to Parents Helping Parents.

At first they are reluctant, belligerent, antagonistic, and yet when those parents get ahold of them and start talking with them and sharing with them, they find out they are not alone, they don't have to be afraid, they can deal with their problems, and they sit down and work on problems and acknowledge the problem. I don't know any other way to do it.

I think that you all play a very essential part and that is why I am pleased to say we have been working closely with Dr. Macdonald, and Abigail Healy from the White House, now chairman of the ABA Select Committee, trying to deal with this problem. We met 3 days this past week. She is chairing that. That has been a new, exciting thing to see happen. The ABA gets into this now. Working with Jim Wooten at OJJDP.

Here is where you all can be supportive to us and not give us mixed messages back home in the local community, because some of the things you do here on the Hill makes our job even tougher, not easier.

I refer to originally when you passed the Juvenile Justice Act in 1974. I just couldn't believe how almost impossible that made our job in the local community to deal with this kind of a problem, even though I didn't know it at the time and the nature of the problem. But it has been corrected somewhat on the Hill.

But there are many, many things that you do here in Washington that directly affect us back home, and again I think it is important that Dr. Macdonald and NHTSA and OJJDP and all your agencies which you fund and control here, also get together and understand the importance of working as a team, developing a national policy on alcoholism, especially as it pertains to children, so that we can all work together as a family.

I call this the extended family of the community. We can't do it alone. There is no way we can do that. We are not in this world alone. We don't solve our problems alone. We all interface and we have to all pull together. How you do that is the key question.

I would suggest to you that one of the best-kept secrets in America is the juvenile court. I think if you can turn on the juvenile court judge in your community, you are going to see some fantastic results, I believe, because he is just a part of it but he can be a major part of the solution to this problem.

Thank you.

Chairman Miller. Thank you very much for that.

[Prepared statement of Hon. Andy Devine follows:]

Prepared Statement of Hon. Andy Devine, Judge, Lucas County Court of Common Pleas, Juvenile Division, Toledo, OH

My name is Andy Devine. For the past ten years I have served as the Juvenile Court Judge of Toledo, Lucas County, Ohio. Prior to that I served as State Legislator, County Commissioner, Toleldo City Councilman and Municipal Court Judge. I am also presently serving as Chairman of the Alcohol/Substance Abuse Committee of the National Council of Juvenile and Family Court Judges.

The National Council of Juvenile and Family Court Judges is the oldest Judge's association in America. It was founded in 1937 and is presently centered on the campus of the University of Nevada, Reno. I wish to send special greetings from our National Council to Congresswoman Barbara Vucanovich, a member of this Select Committee.

Although this paper does not bear the imprimatur of our National Council (I did not have time to run it by the governing board), I believe it fairly well reflects the philosphy of Juvenile Court Judges across the country.

The population of Toledo, Lucas County, is approximately 500,000. The Juvenile Court has 202 employees—I am the only Judge, but I have eleven referees (hearing officers). Our budget in 1984 was in excess of $4,000,000.

The Court heard 15,520 cases, the largest categories being delinquency, traffic, dependency/neglect, paternity during 1984.

Of all the positions I have held, none compare in complexity and importance to that of the Juvenile Court Judge. Consider for a moment the daily decisions of a Juvenile Court Judge—locking young people up—frequently for a long period of time; protecting children from all kinds of abuse; removing others from family and friends and placing them in foster care; permanently separating mother, father and child.

On more than one occasion the Judge is accused of playing God. That's not far from the truth. But thank God we live in a society that protects the rights of children as well as adults.

At a time when children have more than ever before, they are also hurting more than ever before. Look at the frightening increase in teenage suicide, child abuse, mental and emotional illness, alcohol and drug abuse, etc., etc. All primarily due, without question, to the erosion of the family.

What is destroying the family isn't the family itself but the indifference of the rest of society. The family takes a low priority. Think of all the laws, policies, and proceedings that are anti-family. I read in a Newsweek article recently that "parents have not abdicated—they have been dethroned."

It's a terribly complex problem. It is not my intent to point fingers. There's enough blame to go around for all of us. It has always been my practice to light a candle rather than curse the darkness. So permit me to share with you what we are doing in Toledo, Lucas County, to help children with one of their more serious problems—alcohol and substance abuse, and how the family and the extended family—the community—are working together to address the problem.

Three years ago most adults in our community, including myself, were denying our young people had a drug/alcohol problem. Then came a series of "shocking" revelations. A survey estimated there were 13,000 juveniles who were "heavy users" of just two drugs—alcohol and/or marijuana. Seven out ten kids came to Court were "on something" at the time. Juveniles were being killed in auto accidents at an unprecedented rate. Suicides were not far behind.

The situation was intolerable.

In March of 1982, I called seven people from various disciplines to meet with me in my office to discuss the problem of teenage substance abuse. The response was very positive. The group grew very quickly from seven to fifteen to twenty-three to forty. We were on our way.

Not wishing to re-invent the wheel, I went to local industry, raised a few dollars, and fourteen of us traveled to Minneapolis-St. Paul area to do some brain picking. The fourteen represented people from the mental health field, hospitals, police, schools, Court, parents, PTA, etc.

We read everything we could get our hands on and met frequently. We then traveled to Cincinnati to see what programs they had in progress there.

Traveling together out of town as a group accomplished two very important things: 1) we had a chance to learn what other communities were doing; 2) and just as important, we were now working together as a team, sharing with one another and beginning to trust one another.

Right from the beginning we agreed on a very few but very basic concepts: 1) it has to be a total community commitment. Everyone had to get involved. No one was exempt. Schools, churches, police, mental health, United Way, hospitals, doctors, lawyers, everyone had to be a part of the solution because we were all a part of the problem; 2) the most important spoke in the wheel,—nay—more important than a spoke, the hub of the wheel, was parents and family. Without parents and family we were going nowhere. Everyone else, all other disciplines, were spokes in the wheel, all supporting parents and family; 3) in addition to being a spoke in the wheel, the Juvenile Court, after much discussion, played an additional role. The Court became the rim of the wheel trying its best to keep the spokes separate and yet at the same time together so that we could develop a common philosophy and be willing to pull and work together for parents and family.

This is what makes our project different. I did not seek the job. God knows, I have enough to do. But it was generally agreed by everyone that there was much in-fighting, turfdom, denial, lethargy, all kinds of problems that existed in the community that the Court, understanding its power and prestige in the community, could do to bring the entire community together so that we could fight the enemy and not each other.

For example, who else in the community other than the Juvenile Court Judge could go to every school board in the county and plead for help to combat this epidemic problem of teenage substance abuse? Result? Every school board, both public and private, passed a resolution stating that adolescent substance abuse is not a school problem. Rather, it is a community problem. However, since it seriously affects the quality of education in the schools, the schools, because of their extended involvement with children, had to play a primary and significant role to help combat this problem.

There is now a flurry of activity going on in all schools in the county. Support groups are being formed both for parents and for children to help those children who have been into drugs as well as to help those children who have never been into drugs. All school personnel, from the prinicipal to the janitor, are being trained so that everyone understands the problem and understands his or her role in working to solve this problem. We are working with the various police departments so that when a problem is detected that needs attention everyone knows what they should do and how they should do it.

Let's spend a little time on this point because it is such a significant step in the right direction.

One of the first questions asked—as a teacher—What do I do if I suspect a kid is on drugs? If I actually see someone using drugs? Or, if I see someone selling drugs? What should I—what can I do?

To answer these and other questions, all of the school districts appointed representatives to meet until they could develop a common policy and procedure for all of the schools to adopt, both public and private.

It became obvious that the police had a role to play in all of this especially when the teachers actually saw drugs being sold or were able to identify and confiscate drugs. We called together the Chiefs of Police of every district in the county together with the Sheriff and Prosecutor and discussed this common problem. A Policy and Procedure was developed and adopted. It covered school related drug problems as well as any substance abuse situation that they could see developing in their jurisdiction.

Then something very exciting happened. *All* school superintendents both public and private, all police departments, together with the prosecutors and myself, met and worked out together a common policy and procedure for all disciplines to follow throughout the county. This was very important because not only were the police handling these problems differently but frequently, there were two or three police departments within the jurisdiction of a single school district. In order for them to have a common message to children and adults alike, there had to be a common procedure adopted. Since the Court and the police and school districts are now supporting one another, school officials are now free to deal with this problem in an extremely effective way.

As our involvement increased, so did our need to organize. How do you set up an organization with no money? In Toledo, you go to the Junior League. Twice before I went to them with fantastic results. Once to set up the Annual Volunteer Review Boards to help track all children who have been placed out of their homes so that they would not get lost or forgotten in the system. Later I asked them to organize our CASA program, Court Appointed Special Advocates—volunteers who served as guardians ad litem for children who had special needs. Not only did the Junior League organize, recruit, train and supervise these programs, they even substantially funded their activities in order to get them up and running.

In August 1982, I asked the Junior League to help the Court organize this program. They accepted the challenge. Three Junior League volunteers were assigned to the project. One of them, Bette Grotke, has served as chairperson of our group for the past two years, and is now its executive director.

Thus, the Toledo, Lucas County C.A.R.E.S. program—Chemical Abuse Reduced through Education and Services—was born.

C.A.R.E.S. operates under a committee structure and there are presently seven committees: Public Relations, Schools, Treatment, Support Group (Parents Helping Parents, Youth to Youth, etc.), Strengthening the Family, Juvenile Justice/Enforcement, and Finance. We are now incorporated and have qualified as a 501(C)3 non-profit tax exempt organization. Our Board of Directors is truly representative of the entire community, ten representing public agencies and ten representing the public. Agencies represented are school people, both public and private, police, mental health, Court, hospitals, churches, Children Services Board, etc.

We are no longer required to send our children out of the community for treatment. Two hospitals and a mental health service provider are able to care for 80 children at a time. All programs are family oriented.

All Court personnel are required to pay special attention to identify and deal with children who have alcohol and/or drug problems. Parents are requested, and if they refuse, are ordered into treatment with their child or children.

We are not a substitute for family. We support family. This is true of other programs in the community. For example, in our truancy program the Court rarely sees the child. We cite the parents into Court for failing to send their child to school. It is the parents' obligation to educate the child, not the Court's. If the parent is at fault for not getting the child to school, we lock up the parent, not the child.

I trust I have made my point—the importance of the extended family—the community in working with child and family and the role the Juvenile Court plans in this scenario. It is my firm belief that the Court should not only help those children who come before it but also to use its power and prestige to be a catalyst for change in the community.

There are no simple solutions. It's going to take time. This is not the hundred-yard dash. It is the marathon. Like court reform, this is not for the shortwinded. However, in our community, we have at least begun a realistic and hopeful approach to this tragic problem of our time.

I wish to express my sincere gratitude to you for this opportunity to share.

Mr. **LEHMAN**. Thank you, Mr. Chairman.

I just want to ask Judge Kramer a question.

You mentioned the alcoholic driver. We have had testimony before our subcommittee that we have two kinds of people that are involved in alcohol-related accidents: one is the social drinker that just happened to be coming home from an office party or social evening and is involved in an accident; the other, as you mentioned, the habitual alcoholic.

The people say these people should be punished and controlled in two different ways. One should not—not treat the person that is involved that happens to be a social drinker or so forth in that category; but that yet we lost somewhere around 30,000 people killed this year by alcoholic drivers. Not only do they threaten themselves, but the innocent victims involved are of great concern.

Do you have any answers as to how a charge of DWI ought to be handled in the courts with this threat to the lives of innocent victims?

Judge **KRAMER**. I didn't elaborate, but let me do it now.

It is my belief that there are basically two kinds of drunk drivers: The social drinker and the problem drinker. The myth has been that the majority of first offenders are social drinkers.

We do a 2-day assessment, 2 complete days in which we carefully, as I stated before, a number of ways in which we attempt to assess which category they are in. Originally we began to assess them as (1) social drinkers, (2) early in the middle stage problem drinkers, and (3) late stages alcoholics.

In looking over 600 cases, we found 30 percent of 1st offenders to be social drinkers and literally 70 percent divided between the other two early to late stages of alcoholism. As we began to sophisticate our instruments in terms of this testing, we now find we have 20 percent, one of five, who are social drinkers, and we are looking at four out of five who are problem drinkers.

As a result, we have divided treatment into two parts. If the persons are social drinkers, we put them through the Alcohol Safety Action Program—that is alcohol education classes once-a-week for 8 weeks in order to sensitize them to the effects of alcoholism on them. And since they are social drinkers and, can control their behavior, that is all we provide.

But with the other 80 percent that we assess, although they are first offenders, we place them into the 30-week program of three AA meetings and one counseling session a week. The reason for that is that we believe this to be the most effective approach with this population.

It is clear with a court population that AA has had some of the best effects on individuals. These are tightly monitored. We had to work it out with the AA community how to monitor AA meetings. If the offender misses a couple of meetings, they are automatically brought back to court. We keep a tight rein, keeping them in treatment.

Some stick. Sixty percent do; 40 percent don't. But that is for 6 out of 10 that we achieve sobriety.

My suggestion is that it is vital that we do not use one approach, but that we begin to use assessments to find out how to develop a number and a variety of modalities of treatment.

If we do that, we will find intensive treatment will be required for most first offenders because while they are first offender, they are not individuals who have been drinking on the road once or twice.

Mr. LEHMAN. Yet that is to whom most of the advertising propaganda is directed to.

Judge KRAMER. That is correct.

Mr. LEHMAN. So we are really off target as to the main problem.

Judge KRAMER. My view is, and GAO studies and other ASAP program studies strongly suggest, we are wasting our money significantly in those cases, and I think there is a need, at least from our experience, to look at a much more sophisticated way of dividing and assessing offenders and dealing with those of a much more serious nature.

Mr. LEHMAN. When the National Highway Traffic Safety Administration appears before our subcommittee for funding, I will be looking for you for questions, all three of you, to address to them in regards to this problem.

Thank you.

Chairman MILLER. Congressman Wolf.

Mr. WOLF. Thank you, Mr. Chairman.

The reason I jump in, I have a luncheon starting at 12 o'clock, but you were just an outstanding panel and I have a thousand questions.

You are in town, Dr. Macdonald, right?

Dr. MACDONALD. Yes.

Mr. WOLF. I will be able to call you?

From other testimony, there didn't seem to be a concern about social drinkers that drive. But what you said, Judge Kramer, makes us feel it (other programs) was a waste of time because 80 percent are potential alcoholics, I want to ask, do you think the 80 percent is accurate nationwide or just in Quincy?

If we should be concerned about 80 percent of the DWI cases in hypothetical city *X*, do you think it is that way here and in other cities across the Nation?

Judge **Devine**. I can tell you from my experience that in Toledo we do something similar for children who are caught and we have the same results; many of them are problem drinkers and not simply experimenting.

I can't tell if it is 80 percent.

Mr. **Wolf**. In Toledo, a large percentage of those arrested for DWI have serious alcohol problems; is that a fair statement?

Judge **Devine**. Yes, in my experience, having served on the municipal court dealing with that many years ago, I would agree with that.

One of the judges on the municipal court was a recovering alcoholic and he said his experience was the same thing: The ones who get caught generally are not just that social drinker but the one who is a problem drinker.

Mr. **Wolf**. Dr. Macdonald?

Dr. **Macdonald**. I can't give you agency data to support or negate that statement, but my personal opinion would be that an awful lot of drivers who drink and are caught in that act do have underlying chemical dependency problems.

Almost by definition, if you define chemical dependency, as some do, as the use of a chemical substance in a situation that you know may be harmful, you are going to skew the numbers pretty strongly in that direction. This is especially true with the recent changes that have occurred in existing laws and the enacting of the laws that groups such as MADD have lobbied for. It is likely that more and more it will be the problem drinker that doesn't hear that message.

Judge **Kramer**. Let me say, the Massachusetts study statewide shows that 40 percent of all first offenders were involved in other crimes, which means we are not merely talking about a middle-class abuser; we are talking about people who get into trouble, disorderly, assault and battery, all these other messes alcoholics get into. That is statewide.

Second, I am not opposed to advertising to social drinkers because I think it is quite clear that the amount of alcoholism is directly related to consumption. That is true internationally.

The raising of consciousness, as we have experienced with the reported epidemic—even though it was with us a long time—is beginning, as Dr. Macdonald suggests, to have a great effect in raising people's understanding of the effects of alcoholism, and beginning to reduce consumption.

While it is true for alcoholics that advertising won't reach them because they are already into the pattern, and we have to deal with that, with the large number of young people growing up, that kind of publicity is essential in terms of maximizing their awareness.

Secondly, I think it is quite clear that just like the average child will see 18,000 murders on television before reaching 16 years of age and the effect that must have on their minds—and I know this is not confirmed by scientific research—it is my belief that if a boy knows or is told the way you win a woman, the way you get to be successful, the way you enjoy yourself is to drink, when we see that all the time with sports people telling them that, that message has to have a serious affect.

Anything we can do to offset and reduce this is important. It seems to me a matter of common sense that we should try to effect consumption, and advertising obviously has effects on consumption.

Mr. Wolf. Public service ads then do help?

Judge Kramer. I believe that, yes.

Mr. Wolf. One more question. What do we do? Just keep doing more of what we are doing?

How many court systems operate the way Quincy and Toledo do? What do we do to cut the problem off?

Dr. Macdonald gave us the problem; you have told us we should be concerned about 80 percent, of DWI drivers in Quincy. What do we do about it?

Judge Kramer. I will be glad to respond.

I think we can act on a number of levels. At my own level, I go around and talk to as many judges as I can to sensitize them to that and, thankfully, we have judges associations just as the one that Judge Devine is working with which carries out conferences to do that. That is one level.

But it seems to me that if we can begin to take a look at what the myths are by which we have adopted national policies such as the ASAP program and as we begin to find from research, and I think it is important to do that, policies that are based on myths, then it seems to me the supporting revenue which can be prioritized should begin to be put in to encourage those things that do work.

So if we come up with some figures in Quincy, I think it is important to have a research program that can substantiate to what extent that is useful. And if that becomes a finding that is useful, which I strongly suggest, look at your suggestion, it will, it must mean the Congress must begin to provide funding that encourages courts and the rehabilitation world to begin to go in that direction.

I agree with Judge Devine; it is not simple. But I think going in the right direction will eventually get us there.

Judge Devine. Many immediate things can happen, and Dr. Macdonald can address some of these because he is actively involved in just that scenario which I am really encouraged by.

You know, there is a lot of funding that comes from the Federal Government down to the State, down to the local community. For so many years it has created kingdoms and not cooperation. There has to be some requirement to cause some of that money to be used in cooperative effort to bring communities together on this issue.

It just seems to me that there are so many things, NHTSA, and the amount they spend in terms of education, if it is done in a comprehensive type of program and not just targeted. Because when you target programs, you've got to be careful because you create kingdoms, you create turfdoms, and that is one of the main problems we had in our community, why we were not doing anything; everybody was protecting their turf.

Working with children is a good way to go. In treating children you touch many disciplines, education, health, recreation, mental health, juvenile justice, welfare department, and so forth. All departments and agencies should be working together at all levels, Federal, State, and local.

It goes back to the State. The State has to do the same thing.

One of the neat things that happened in Toledo is that we have now caused the State to form a coalition of cabinet members of the State to sit down and talk together when it comes to a problem concerning children, because the Welfare Department, the Department of Education, the Mental Health Department, all frequently deal with the same child and rarely does it just touch one agency. That child usually goes across three or four agencies, but the agencies are not talking to one another. It is amazing.

Recently, at a NIDA Research Conference in Washington, a researcher came in and produced layovers where the Department of Highways had this information on this child; the court had this information on this child; the school had this information on this child. When you put it all together, you get an entirely different picture of this child than when just one agency looked at this child.

So there are many, many things that have to be done in my opinion to bring about that concentration of effort in this area so that we are all pulling together as a team.

Mr. WOLF. If you have any comment, Doctor.

Dr. MACDONALD. I don't want to ruin your lunch. I have a lot of comments, but I will make it short.

I like the statement that Marjorie or Bev made that we together can do it but we can not do it alone. I think one of the things that has been demonstrated is that the Federal Government is a part of, but nowhere near the whole, answer.

Judge Devine's experience came from Ohio. Judge Kramer's came from Massachusetts. In visiting many States, I have found that there are lots of concerned people, like those in Baton Rouge. I have been in touch with them and in listening to each other, we can make changes.

Going a little further, there are three problem-groups, we need to address and deal with. The answers differ for each group. There is the problem of the addicted regular user. They need treatment, or need to be off the street.

We need to deal with the kids that have not yet begun. There, efforts at prevention are extremely important.

And we need also to deal with the regular user who is accepting of abuse, because they are also a major problem.

I use my four A's of prevention. I think the four things we have to look at is availability; as availability is decreased, there is less beer or other alcohol to be consumed. If kids don't go to keg parties, they don't drink at keg parties.

Two others are attitudes and acceptance. It is society that accepted alcoholism and drunkeness and laughed at Dean Martin and Foster Brooks, and we need to change that.

I was distressed by the young man sitting here really believing the only way to get through adolescence was by drinking. I think we have to change that and say it is OK not to drink.

I met a girl from Kansas City High, chairman of the student council. What she said is the student council at Kansas City High made a pledge: We will not drink; we will not use drugs; we will make it known; approach all freshman in this school; and we are going to say, "You don't have to drink or smoke to be an important part of Kansas City High."

I have heard that from kids all over the country.

The fourth A, is aversive consequences. We have to make the laws that are on the books stand for something, and we have to make people aware of the negative medical consequences of alcohol and drug abuse. People die from it.

Another consideration is that kids are different from adults and we have to treat them differently. I don't take a lot of stock in saying what we do with 13-year-olders should be the same as we do with people in their midtwenties. I know that from a lot of years of being a pediatrician that children and adolescents are different. They need protection.

Judge **Kramer**. I would add one point to that.

Aside from dealing with what I called the wounded, those who come to the attention of the courts, in terms of the general approach, it seems to me we are a drinking society and I think prohibition pointed out that trying to get people not to drink was not the most effective way. Maybe eventually we will reduce consumption, but that can't be the policy edge.

It seems to me it comes to the point where we must alert those most at risk to understand why they are more at risk and others who may be getting into trouble to understand when that drinking is getting them in trouble.

So for children of alcoholics, it is vital, while there is an active drinker in the family, to pick them up. We should deal with them while they are not yet drinking because of what will happen if they do. Whether it is genetic, and the evidence is mounting, or not, or whether it is the result of the home, we must begin to pick them up very, very early so they can understand they have some choices.

We have to pick up coalcoholics who must understand, particularly grown-up children of alcoholics, that they are at risk even while they are just starting to get married and into relationships that may be that way.

Third, to let people know who may not be in those categories what are the signs.

I was in politics at one point and came back from the State house and went across the street, and drinking was a way of life after work because that is where you went; and I did not know that there were some in that crowd—thankfully only by chance, it was not me—who stayed a little longer, drank a little more, and did it a little more often, and they were serious problems compared to those of us who had two or three and left.

It was hard to tell the difference among us. We went to the same bar, had the same drinks initially, and started with the same good will, but there is a difference. And as we begin to understand the differences, maybe we can sort them out and help people sort themselves out.

Mr. **Wolf**. Thank you very much.

Thank you, Mr. Chairman.

Chairman MILLER. Congresswoman Boggs.

Mrs. BOGGS. Thank you, Mr. Chairman.

I thank all of you.

Dr. Macdonald, could you please tell us how prevalent alcoholism is among women?

Dr. MACDONALD. Yes, alcoholism is tremendously prevalent among women.

We did a survey at the National Institute of Mental Health looking at a number of alcohol, drug abuse, and mental health disorders, and the percentage of use or of disorder was 6 or 7 percent of the adult population, with higher proportion of men than women. However, alcohol problems among women are of sufficient magnitude to warrant increased attention.

In terms of numbers, over 10 million American adults have alcohol problems.

Mrs. BOGGS. So it is no longer a hidden problem as it was at one time?

Dr. MACDONALD. It is a hidden problem for a woman in the sense that it is harder for a woman to come to grips with it. Employers have less acceptance of a woman who drinks; spouses are more likely to divorce a female than male spouse.

Women are at higher risk for the consequences.

Mrs. BOGGS. Earlier today when we were told by the young mother who had to give up her children in order to complete her treatment for alcoholism at a resident treatment facility, she indicated there seems to be considerable pressure to split up a family in order to take advantage of treatment and vocational rehabilitation.

Is your agency aware of this treatment dilemma that, apparently, faces many mothers with substance abuse problems?

Dr. MACDONALD. No. I was not aware that it is common practice to deny child care services as part of the overall treatment regime for women who are being treated for alcohol and drug abuse problems. As a matter of fact, I find this a little surprising since when NIAAA and NIDA directly funded treatment services they had policies supporting the provision of child care services when the lack thereof would be a barrier to a women's recovery process. In the case you cite the fact that the woman needed to develop job skills to enable her to become financially independent added an additional dimension to her needs for assistance in caring for her children. However, I think that goes back, Congresswoman Boggs, to the previous comment that women really are at a disadvantage in the health care system for a number of reasons.

Nevertheless, one of the things we know, and stress, is that you have to treat the whole family of a chemically dependent person to see results because when treatment is over, the patient needs a support system to go back to.

Many times the family is dysfunctional. Also the spouse may be alcoholic or drug dependent. As a person that cares about young people and children, I like to keep families intact and would do nothing to split them.

I don't think that there is anybody here that would promote that approach. There are extenuating circumstances, in some cases, obviously.

Mrs. **Boggs**. Thank you so much.

Judge Kramer, though you didn't say so in your testimony, I know that your program has reduced recidivism so considerably for the 60 percent of the problem drinkers who finished the intensive treatment program.

Would you like to comment on that?

Judge **Kramer**. I would like to be more reserved on that because we are just undergoing with the State authority a more controlled study.

The study that is in our report was done by the programs themselves, which I tend to distrust. The recidivism rates can vary based on whether you are talking within a 2- or 3-year period. I am reluctant always to publicly indicate and always give caution when people indicate recidivism rates.

I would say it is heartening what we have seen. The results from the program people is OK, but until we compare with the control group or random study, my suggestion is to hold back on those without making any major claim.

I would say that from a percentage subjective point of view and from statistical tallying of the programs, we look good. But I don't want to put that down right now.

Mrs. **Boggs**. And can you tell us more about the sexual abuse connection of alcohol that you mentioned in your testimony?

While alcohol appears to be connected with violent behavior, there has been very little information of how it might connect to sexual abuse, which is a very different kind of child abuse problem, of course.

Judge **Kramer**. I wish we had undertook the same study with the total child abuse and domestic use cases as with sexual abuse. I can't give you an exact statistic and all. We are about to do that in the next couple months.

I can only suggest to you that I have sat on very large numbers of child abuse and sexual abuse cases and there appears to be very little difference—and I can quote national studies and submit them to you—but little differences between the percentages.

Our percentage with child abuse is running somewhere between 45 and 55 percent for child abuse. I haven't seen any difference with sexual abuse, meaning, when the act of child molestation, particularly in homes of abuse, parent, caretaker of some child or stepparent or cases outside the home, but largely it is in the home, they get reported easily. We are looking at a parent under the influence of alcohol at the time and also one who is an alcoholic.

I also don't want to suggest that if you just cure that alcoholism in that case, you necessarily cure the sexual aggression. I think that would go too far.

I would say without making that statement until that is looked at, that unless you deal with that alcoholic, you won't get close to dealing with the underlying problems which exist. I think those are a little more complex.

I would make statements that in many other cases, just dealing with the alcoholism alone, while it doesn't complete the recovery of the person in other respects, will probably stop a great deal of behavior we see.

But in sexual abuse, I would be far more conservative because there are complex issues. Even when we stop the drinking, we have seen that continue to occur.

There a totally different treatment is required: Getting the husband to take responsibility for the act, getting the child to get rid of the feeling of guilt, making sure that the parent who commits the act is taken from the home rather than the child—which happened in the past, the child is taken out, and the whole family conspires against the victim rather than the abuser.

All those dynamics and treatments have to be regarded. But my suggestion is still clear: There is a high correlation of alcoholism while that is going on.

I believe you have to deal with that before you can get the family to just go to meetings and not miss them and go into treatment. So, it is the same problem, although I think the outreach solution is a little more complex in treatment approaches.

Mrs. BOGGS. Thank you very much, Judge Kramer.

Judge Devine, I loved your description of the family being the hub of the wheel and the court system being the rim, that in addition to acting as a spoke, it holds all the spokes together.

You referred to the 1974 Juvenile Act and you said that you didn't know the extent of the problem at that time. You were talking about problems that you dealt with.

I think that was true of the Congress. We didn't know the extent of any problems that we were addressing at the time.

That is why this committee was really formed, to look at the family, as you do, in a holistic sense, to know it is the hub of our society and to try to find out as much as we could possibly find out about the entire family and its position within the society and of society's impact on the family.

So we are grateful that we have someone such as you in the position you enjoy nationally as well as the one that you enjoy at home.

Could you tell us if you have any statistics that you can share that show the impact the community effort that you have inspired is having on reducing the numbers of young people who are heavy users?

Judge DEVINE. I didn't hear the first part of the question, sorry.

Mrs. BOGGS. Do you have any statistics you can share with us to show what effects your community efforts have had on reducing the number among young people of heavy users?

Judge DEVINE. No; but we have on file an application with NIAAA, an agency under the jurisdiction of Dr. Macdonald, to do just that. It is a 5-year study to document the advantages of interagency cooperation using the family as the focal point.

You know, parents today are really hurting. They don't know where to go. I heard it this morning from Mrs. West and her husband who identified a problem and really had a hard time getting a handle on it. I deal with those all the time. They are coming forward to the court for help in unbelievable numbers because previously they perceived the court the last, most depressing, the most obnoxious place to go for help. Now that they understand the court is there not to hinder their parenting but to support their parenting, it is a friendly court, a supportive court, they are coming to us in untold numbers for help.

You can see how that scenario can build. Now they have the support of the court, but the court can provide the hospital support, the school support, the mental health support in the community so that no matter where that child goes, and the followup support that Dr. Macdonald points out, which is so critical to this, that all of that is in place.

We are just another part of the piece of the puzzle that goes into all that, but as a result of that involvement, let me tell you there are tremendous numbers—and we have identified, can you believe this, 13,000 kids in Lucas County who are heavy users of just two drugs: Alcohol and marijuana. Thirteen thousand in our small community, heavy users, not experimenting users but heavy users. It is just mindboggling the problem that is out there, and even though I am encouraged about the slight decrease, let me tell you there are thousands and thousands of families and children out there hurting who need our help.

Mrs. **Boggs**. One of the facts about alcohol abuse is it becomes increasingly evident that it is a family difficulty, and it runs in families. It would seem, given this fact, targeting children of substance abusing families with special support groups, that that might be effective. Does your program do this, or does it focus on children who started abusing drugs and alcohol?

Judge **Devine**. We recognized we cannot neglect one and do the other. We have to do both. We have to get involved in prevention as well as treatment. That is our goal. That is why we work so closely with the schools. We perceive schools, working with parents and the community, can get into the area of prevention and really have a significant impact, and, of course, we started our program with seventh and eighth graders, we are down to fifth and sixth and now we are talking about going all the way down to kindergarten in working with schools, parents, and child through the entire educational process.

The thing we have found which is rather interesting is that as our enthusiasm grows, we are tempted to do it for the parents. That is not right. We have got to do it with the parents, we have to support them, but they are the ones who have to do it. I gave in my speech, or the written speech, the courts' attitude, even on truancy that the court should not be responsible for getting the kid to school. That is a parental responsibility.

What I do is I don't even talk to the children, I deal just with the parents. Unless he is 6 feet 4, and totally out of control, then I will deal with the youngster and the parents. But especially kindergarten through six, I deal just with the parents. I bring them in, and if they are responsible for not getting the child to school, I will lock the parents up, not the child. I deal strictly with the parents.

It is amazing how successful that program is. I agree with Judge Kramer, the carrot and sticks, you have got to have both.

Mrs. **Boggs**. Thank you very much, Mr. Chairman.

Chairman **Miller**. Congressman Coats.

Mr. **Coats**. Mr. Kramer, I wonder if I could ask you a followup question on your testimony.

I noticed in the first panel, and maybe you did too, that there seemed to be a common thread that ran through the description of why each individual turned to alcohol: "I didn't feel good about myself, I wanted to be OK, and I couldn't feel OK unless I consumed alcohol; then I felt better about myself."

You have a section in your testimony that talks about low self-esteem of the children of alcoholics. Am I right in pursuing this as a common—I know you are not a psychologist and neither am I—but as a common underlying theme, do you see this over and over, and, if so, should we look at prevention and treatment with this as a factor?

Judge **Kramer**. There are two different places where I have gotten the experiment to at least know the limits of my statement as well as experiences. No. 1, I have sat, obviously, in a large number of cases, so I have seen the court population that may be different than outside population, but I have seen the court population groups. I have no reason to believe they are significantly different, but maybe they are. So, in hundreds of cases, I have read reports, investigative reports, clinical reports and talked to the individuals.

Second, because of my high interest in AA, because I began to realize it was very important, I began to go to many meetings, although not as a drunk, listening to them telling their stories to other people. I am impressed that the statements made there were not different from statements in court. We have seen large numbers of people who are expressing that because they were under peer pressure, and all that is true, many came from homes of alcoholics and many felt of less worth than the people they were peers of because of the devastation in the home. We heard that today.

They began to talk about paying the price for the sins of my father, almost suggesting they grew up with this. One can understand that, because as I would talk to them, he would say, "He would come home, we could not talk with him, we pretended he was not drunk"—using the wheel analogy, if you have a wheel with a bent spoke, everything bends, and everybody is behaving in an unnormal way to make that wheel continue to go.

So the whole family begins to adjust to a family situation and begins to bend and act abnormally, and they believe that the quietness around this person and hiddenness and secretiveness is how you live. So they grow up with this. At least I found that. Unless somebody can give support to them through self-support groups and the rest, as the people did today, and show them that that is really abnormal, that you deserve more, that you are not at fault, you really have a choice, that low self-esteem or feeling they are hiding something as if it is their own guilt, and what you do as a little kid, as with a parent, that is what you do.

That is part of it; therefore, it becomes important whether they are drinking or not, they are dependent in a sense, they have been wounded by alcoholism, which they themselves have a disease from being around that, so that is what they have to deal with.

I think that is a very central part to dealing with the issue.

Mr. **Coats**. In that first panel, I was searching for a common denominator in terms of the treatment programs, and various ones said they turned the corner or became aware or something happened. Is this a consideration in the type of program you establish? Please feel free to comment also, Judge Devine.

Judge **Kramer**. There are a number of approaches, there are a number of 30-day in-patient programs or 28-day programs that we use for people who are more serious, and I think that was one of the programs that was involved with Bret. He went away for 28 days where they spend their entire time, hopefully, trying to get them to understand the problems, to go to AA meetings and deal for a whole month with nothing but their drinking behavior as a mirror and set up an after-care program when they get out.

You can work within the community without having to commit to that amount of time in which you can get people involved in these support groups and AA groups. I think it depends on the individual. They are all effective, but they all deal with alcoholism primarily. They don't begin to deal with the social problems first.

What I think does not work is when people have problems, and they drink, and they are referred to a therapist and the therapist has no idea of the alcohol or family background and begins to deal with the underlying social or psychological problems even in analysis counseling. I think that is doomed to fail because when they begin missing meetings, they have not been sensitized to the alcoholism. I am one who feels you should get them to support groups for alcoholism first and as they begin to stop drinking and keep them from drinking, to get them into the other problems involved. I think it is a change from what goes on, and it is an emphasis that this committee may wish to look at in terms of treatment options in terms of what they fund or support in the future.

Mr. **Coats**. Judge Devine, in your Toledo program, how extensively have you been able to disseminate the information about your model and its success to other communities? Is there a mechanism in place to do that?

Judge **Devine**. We have just begun to put this mechanism in place. The committee I chair has been in existence a little over a year. We have been working with ADAMHA, which is Dr. Macdonald's agency, with NHTSA and with OJJDP. They have all been very helpful. Our first job is to educate the juvenile court judges across the country and to get them involved not only in the area of treatment but in the area of prevention much the same way that we have done it in Toledo. There is no question in my mind that it can be replicated and very inexpensively. Many of you know how helpful the juvenile court judge has been in the area of permanent planning for children, getting kids out of foster care and into permanent homes. The juvenile court judge can be equally helpful here.

Mr. **Coats**. Dr. Macdonald, one last question, do you have any specific thoughts regarding the prevention side rather than the treatment side of all this? What kind of things, if anything, can the Federal Government do in assisting in prevention? You mentioned awareness and that type of thing, do you have any additional thoughts on that subject?

Dr. **Macdonald**. One of the things Congress put in legislation for ADAMHA last year, was the creation of the position of Associate Administrator for Prevention in my office, I am about to fill that position. What we, as a research agency, are involved with is evaluation of prevention programs, such as Judge Devine's program. I think we can really offer support in the research area by saying what works and what doesn't, and what works when. What we want to be is a national focus, to be involved with the National Federation of Parents, PRIDE, MADD, and other organizations. We have a lot to offer.

I am so personally committed to prevention that I am going to do what I can to keep us highly active in this area.

Mr. **Coats**. As you fill that office and get into that and come up with recommendations, I am sure the committee and I personally would appreciate your keeping us informed of what your thoughts and what your needs might be. I think we all realize that we have to somehow find a way to stem the ever-increasing flow of new patients to treat. We want to stop those people from becoming patients in the first place. So, let us know how we can help.

Judge **Kramer**. I am impressed with the fact that the question has been asked a number of times, and we get all kinds of different answers. I am quickly reminded, being from Massachusetts, of President Kennedy who said, in response to the question concerning why he did all that campaigning, when only a small amount did the job. He said, "Sure only three percent does, but we don't know which three percent does, so we do it all."

So, I think we will have to cover all these fronts in the courts, the community as Judge Devine says, to do it all, and they will all make a difference. I am not sure we will ever know which one specifically, but in general, they will.

Mr. **Coats**. Thank you.

Chairman **Miller**. Congressman Levin.

Mr. **Levin**. My only question, Mr. Chairman, is an appropriate follow up, I think all of us agree with Judge Devine, that the whole community has to be involved. Since we are in Washington at the moment, let me ask this question, if each of you might just address it briefly. What do you think the Federal Government should be doing which it isn't doing now? And what do you think it should not be doing that it is now doing or attempting to do in relation to alcoholism?

Judge **Devine**. Fifty words or less, Mr. Chairman?

Chairman **Miller**. You better be right.

Mr. **Levin**. It is a question that could be answered at length but——

Judge **Devine**. First, I think it is important that the Federal Government develop a national policy on alcohol and drug abuse as it affects children.

Second, even under present appropriation I think the Federal Government ought to earmark a portion of that money to be used to stimulate local cooperative efforts to address this problem again mandating that the families be the key component.

Third, I think all special grants given by whatever department should reflect this common philosophy.

Last, I think that through the Department of Education some areas should be selected to develop a prevention program again in conjunction with and not isolated from the community.

I think Dr. Macdonald and Jim Wooten and others and Abigail Healy from the White House are making an effort to try to cause that to happen. I applaud them, and I think it is great.

Mr. Levin. Judge Kramer, what would you pick out as two or three points?

Judge Kramer. I think I would probably try to develop models which I would tie the purse strings to. One of the most effective pieces of legislation dealing with domestic abuse, which was adopted very, very quickly in all the States within a 5-year period, was this Domestic Abuse Intervention Act which basically permitted courts to start giving restraining orders and start giving vacate orders in abusive families and intervene dramatically. All the States passed this very quickly across the 50 States because models developed.

It seems to me if this committee were to be the committee that began to sort out information and began to encourage whatever agencies to develop whatever models to work with alcoholism in domestic abuse and child abuse, to develop the models and supply funding to the courts, once you have reached those policy decisions and began to entertain the models, you would encourage State legislatures and other policy areas to adopt them. First, you have to decide the issues and, second, develop those models for support.

I think, second, just the information that this committee has becomes publicized in ways that people can get it. For instance, I constantly read the literature, so I am involved with alcohol abuse literature that comes out, but one has to devise the ways that promotes this information in less esoteric ways to begin to reach judges and destroy the myths, for instance, that alcoholics are not involved with first offender OUI programs, whatever decisions you make. So, one is educational in terms of encouraging that kind of thing, but, two, developing models; and, three, evaluating the models.

There is no way we will have the collective wisdom to know that models work. That means constantly evaluating and changing and encouraging the feedback into law on these. I know the difficulty there is once something starts to change it, so I imagine the initial choices of what you put out there will have to be quite well thought out, at the same time you can't be held to be right, and information changes. So, the system of developing models, tying finances to encourage them, getting feedback, encouraging people to understand the feedback—I think it is the best we can do.

May I just add that I think there has been enormous efforts in the last 8 or 10 years in this whole area, thanks to the Congress and to some of the States in this area, and the President's Commission on Drunk Driving and all the rest. We ought to pause while we worry about the difficulties that face us, but also understand there has been a lot of progress in which all of you should be quite proud, and I think it is going to be true of the future chapters as well.

Dr. Macdonald. That is a tough question to answer in a short time. When I took this job, somebody asked what I wanted to do and I said what I wanted to do was be a doctor. That is what I feel my role is, to be a clinician who deals with, on the one hand, a group of people who study all these problems and another group that puts these research findings into practice, understanding they both have a part of the equation.

I see the role of ADAMHA being that understanding or listening to the parts of the world that hurt. That involves in our case such things as teenage suicide and a number of other complex problems. What we have to say in some cases is that we don't have enough information, but we can't stop there. We have to say on the basis of what we do know, we want to recommend that we do these things to help right now.

That deals ADAMHA being part of the national focus that addresses the problems even though all the data may not be complete or are not yet well evaluated. At the same time, we are a research organization, and we need to continue to stay involved in better understanding the biomedical and behavioral bases of these problems, the cost issues, some of those things I mentioned earlier.

I don't know that the Congress needs to do a whole lot more than what you are already doing. I don't think our basic laws are terribly out of whack. If somebody asked me how much money we need, I would have to say "What do you want done?" It is a hard thing to get a handle on. But I feel very comfortable in saying that what I think is happening is movement in the right direction.

Mr. LEVIN. Thank you.

Chairman MILLER. One of the things that this committee has tried to do is to try not to sit in this committee room and come up with ideas, and then require people to administer them across the country. We have tried to listen to people from local communities and see whether there are things to be learned and whether the successes can be replicated.

This approach is drawn from my own personal experience in writing the Foster Care and Adoption Program. We spent almost two years listening and traveling around the country talking to mainly juvenile court judges and social workers and other people who had to live with the current law. What we found was a system that was antithetical to placement, and not getting the most out of the revenues that the Federal Government was at least putting out there.

Since the new law has gone into effect, I think, in fact, things have changed dramatically. At least we have sensitized HHS and others about the placement of these children. What the law did, in a way was to put the juvenile court judges and the court system in the role of family practitioner. Again, using the models that you have used here, laws become like the hub of a wheel. When we were in Louisiana, for example, Judge McGee from the National Council, used the Education of the Handicapped Children's Act to force school districts which did not provide these services to reach out and do the job right.

It doesn't matter, really, which law or organization is used as the starting point. But what becomes very clear is that somebody has to have responsibility in the community for bringing the effort together. Maybe the school system can do a better job of prevention and detection. But many young people from each community pass through a court room as well as violators or families of violators, or what have you.

It seems to me that the approach we had in the Foster Care and Adoption Program may be something that we should consider here. I don't know if we necessarily want to do it legislatively. Dr. Macdonald talks about the programs that are in place. But if they are in place and we still have the problem that is being described to us, they are not in place as well as they should be. I guess the question that we would ask is: How do we achieve the kind of leverage that we would like? Because the leverage that we have out of the few hundred million we spent in foster care money, to get the States to come around to a system of permanency, is really rather dramatic.

The question is how do we achieve that kind of leverage from the Federal point of view? Because we are not going to have a Federal program on drug abuse treatment and prevention. It doesn't work that way, as you have said. How do we provide the leverage so it is not just Toledo, it is also Cincinnati, San Francisco, Concord, New Orleans, so we start to move the successful approaches elsewhere in the country?

It was a carrot and stick approach that got foster care going. Preventive services were put in place, or payment for maintenance was lost.

Judge **Kramer**. You encourage a thought process for me as you do it. I am devoted to developing community services and restitution programs and went across the country doing that. It has been emulated now. I watched it come back to haunt. In the driving under the influence cases, they began to experiment with community services as an alternative to jail or other things for alcoholics. While I was one of the first involved with that, I said how ridiculous, five or six days' community service. How can that effect that?

You look at the juvenile justice system, when we got a lot of what has been happening, such as the Center for State Courts developing programs and alternatives, but not being sensitive to alcohol; I know that alternatives for a number of juveniles at the community without an alcohol component is doomed to fail in those cases. Maybe that suggests that one ought to look at, instead of to a program, to a number of things that exist where we have now gotten information where alcoholism may be involved and amend either the funding programs or the statutes with the words "alcohol-related programs."

Put them in so people will begin responding to see that as another dimension within what the effort is and so the community service and restitution programs alternatives are joined by this. What I am saying is perhaps we look at it across the board where we have directed certain programs, and we add those words in areas where the words have not been added as a result of information you have gained in these hearings.

Am I confusing?

Chairman **Miller**. No, you brought up the Juvenile Justice Act, and I assume you are talking about status offenders, and our ability to get their attention in a serious manner. But we found out when that came about that there were a lot of judges arbitrarily throwing kids in jail, which is also a problem.

Judge **Kramer**. I wasn't referring to status offenders. I am one who does not believe that we should treat someone who has not committed a crime as if they are a criminal and truancy is not a crime.

Chairman **Miller**. I understand.

Judge **Kramer**. I am talking about juvenile delinquency cases where we try to come up with alternatives, and in those cases where the people are offenders, we are adopting alternatives to incarceration, and alcohol programs for the kid and family members would be encouraged within the applications for funding or within the policies that are there as part of the total package of dealing with delinquency.

I suggest that we will find that that total family approach is really not emphasized within those approaches to delinquency. Perhaps that is an example of a number of other——

Chairman **Miller**. I am not suggesting that we put the courts in the middle of this problem—I suspect they are there without us. I am just searching for a catalyst in the community that can help those who may not be addressing the problem or are ignorant of it, or refuse to move because they are self-conscious. Clearly, we don't want to add billions to the Federal effort. But can we do much more to make sure that the resources in the community are being maximized?

It seems to me that because so many with alcoholism-related problems come through the court room that we ought to start looking to it as such a resource. The school system apparently doesn't have the necessary leverage with parents. Schools are more easily ignored. But courts are not. We have seen a number of programs by the National Council in different communities that suggest courts can play this role.

Let me say—and I don't want to characterize your position—I am not comfortable at all that things are working well with respect to the interventon and prevention efforts we have going now, Dr. Macdonald. There is a lot more that can be done.

Dr. **Macdonald**. I don't want to leave that impression either. Even though some trends are inching in the right direction, I think we are in terrible shape.

You used the word "general practice." A lot of what we do is practicing. We adjust and modify and use things we already have. Judge Devine and I both met with the American Bar Association this past weekend. They have a commission that will make a number of legislative recommendations which we are not free to discuss today, dealing with the issue of youth, drugs and alcohol.

I also met with the American Academy of Pediatrics recently and they too, are getting ready to make recommendations. There are things coming that we have to change, but at the Federal level I don't know what they are yet.

Judge **Kramer**. Perhaps I can be clearer. Take the truancy issue, a lot of people get involved, the school detects it and tries to deal with it, it may come to the courts using the leverage to deal with the status offender. Take those two. I don't know the leverages, either with money or others, to be used on schools to make them more sensitive. When they are dealing with a truancy case, they are finding a number of cases around alcoholism that they are clearly missing today.

One would have to review what is in the laws now. We may want to add that incentive. I don't know what is in the court systems in terms of money or other ways of dealing with courts to take a better look at truancy as looking for maybe alcohol problems that you don't see today where we know the percentages are high.

What I am saying is perhaps we look at the leverages, whatever they may be, and add those kinds of incentives to look at this total problem of alcoholism, which we know or find out are significant areas. I can't remember those specifically today——

Chairman MILLER. Perhaps we try too hard around here to find the perfect solution.

Judge KRAMER. I think rather than looking for a central alcohol group, there will be a number of central pieces. Unfortunately I wished—maybe I should wish that we were so divided, but I think the fact is that we do have a number of groups, and that means we are just going to have to deal with that reality.

Chairman MILLER. It is a major step when a community decides to focus on the family. I can remember a number of years ago when Congressman Coats' Senator, Senator Lugar tried to get people concerned about children to find out where they are, and the various paths that children come through where you have a chance to have impact on their lives, whether it is in the school system or court system. His ultimate goal was to start to marshal resources to those places, because you only get a few opportunities. As parents, we all know our chances to have an impact come and go quickly. So we need to focus our efforts where they will do the most good.

The previous panel suggests that once you start that the lights go on in a lot of people's heads who have not looked at the alcoholic components of the services they were delivering on a daily basis. So I think it is a beginning. I am encouraged by it, so much the better. The juvenile court judges have done so much, really pioneering stuff.

Judge DEVINE. May I commend the chairman for his role——

Chairman MILLER. You can respond, and I promise I won't.

Judge DEVINE. I simply wish to commend the chairman and Congress for their role in helping the local community deal with the problem of foster care drift in our area as well as throughout the country. The process of putting together a permanent plan for children who have no permanent home is finally taking shape. As Congress has played a significant role in that very difficult problem area, it seems to me they can play the same role in this problem area of alcohol and substance abuse on the part of our children. The kids in our community are.

Chairman MILLER. Thank you very much. My thanks and the committee's thanks to the entire panel. As you can see, this is our survey course and we will be back to you.

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, DC, April 3, 1985.

Hon. ALBERT L. KRAMER,
Presiding Justice,
Quincy District Court,
Quincy, MA.

DEAR JUDGE KRAMER: This is to express our personal appreciation for your appearance before the Select Committee on Children, Youth, and Families at our hearing, "Alcohol Abuse and Its Implications for Families," held here in Washington March 18. Your participation contributed greatly toward making the hearing a success.

The Committee is now in the process of preparing the transcript of the hearing for publication. It would be helpful if you would go over the enclosed copy of your testimony to make sure that it is accurate, and return it to us within three days with any necessary corrections.

Also, we would greatly appreciate your answering the following for the record:

1. How is your comprehensive alcohol assessment program funded?
2. What resources are made available to serve individuals and families in the various mandated treatment programs?

Let us again express our thanks, and that of the other members of the Select Committee for your testimony.

Sincerely.

GEORGE MILLER,
Chairman, Select Committee on Children, Youth, and Families.

WILLIAM LEHMAN,
Chairman, Task Force on Prevention Strategies.

LINDY (MRS. HALE) BOGGS,
Chairman, Task Force on Crisis Intervention.

TRIAL COURT OF THE COMMONWEALTH,
QUINCY DIVISION, DISTRICT COURT DEPARTMENT,
Quincy, MA, April 22, 1985.

GEORGE MILLER,
Chairman, Select Committee on Children, Youth, and Families,

WILLIAM LEHMAN,
Chairman, Task Force on Prevention Strategies,

LINDY (MRS. HALE) BOGGS,
Chairman, Task Force on Crisis Prevention,
House Office Building, Annex 2,
Washington, DC.

DEAR CHAIRPERSONS MILLER, LEHMAN AND BOGGS: Enclosed please find a corrected copy of my testimony delivered on March 18 regarding "Alcohol Abuse And Its Implication For Families". Please excuse the delay since I was on vacation during the past week.

With respect to your further questions regarding how our comprehensive alcohol assessment program is funded and what resources are made available to serve individuals and families in the various mandated treatment programs, I would add the following:

With respect to funding, in the case of first offenders convicted of driving under the influence of alcohol, they are assessed (as part of the disposition) an amount of $595.00 to pay for both the assessment and the thirty week mandated alcohol counseling and A.A. program. Our program differs from the Massachusetts state-run conventional ASAP program of an eight week duration, which fee is $280.00. The Commonwealth subsidizes that $280.00, in cases where the court finds the offender to be indigent. Since the Commonwealth has approved our program on an experimental basis, we may also waive a portion of our fee up to $280.00, in cases where offenders are found indigent.

Our program is also mandated for individuals on probation who have been assessed to be alcoholics. In these cases no waiver is permitted. The offender, however, is given a payment schedule over the period of probation to pay for the program.

In cases of sexual abuse, child abuse and status offenses, where individuals or family members are referred for assessments, we have arranged for nonprofit and state counseling agencies to provide assessments and treatment on a sliding scale.

With respect to providing resources to families our thirty week mandated program for individuals on probation or convicted under the influence of alcohol is reduced to twenty weeks, in instances where the offender is able to obtain agreement from a family member or a significant other to join him or her in the program. In this instance, the program is reduced to twenty weeks and a significant other must join in the counseling session each week and while the offender is required to attend three additional A.A. meetings a week, the significant other or family member is required to attend one Alanon meeting.

We refer over one thousand individuals a year for assessments and for program treatment consisting of offenders who have been convicted of operating under the influence and other crimes, as well as children and family members in juvenile and abuse matters that come before the court. Since the court establishes the fee, we award the program to an agency based on a competitive bid, depending on the resources they provide. The program provides psychologists who administer the assessment testing and certified alcohol counselors who provide the treatment.

I hope that this further information is of some assistance to you committee.

Sincerely,

ALBERT L. KRAMER,
Presiding Justice.

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, DC, April 3, 1985.

Hon. ANDY DEVINE,
Judge, Lucas County Court of Common Pleas,
Juvenile Division,
Toledo, OH.

DEAR JUDGE DEVINE: This is to express our personal appreciation for your appearance before the Select Committee on Children, Youth, and Families at our hearing, "Alcohol Abuse and Its Implications for Families," held here in Washington March 18. Your participation contributed greatly toward making the hearing a success.

The Committee is now in the process of preparing transcripts of the hearing for publication. It would be helpful if you would go over the enclosed copy of your testimony to make sure that it is accurate, and return it to us within three days with any necessary corrections.

Also, we would greatly appreciate your answering the following for the record:

1. You have described a community-wide effort addressing problems of substance abuse among young people. Would you tell us more about specific strategies and practices that have been developed to help parents and other family members cope with the abuse problems of their children?

2. How is the program in your community funded?

Let us again express our thanks, and that of the other members of the Select Committee for your testimony.

Sincerely

GEORGE MILLER,
Chairman, Select Committee on Children, Youth, and Families.
WILLIAM LEHMAN,
Chairman, Task Force on Prevention Strategies.
LINDY (MRS. HALE) BOGGS
Chairman, Task Force on Crisis Intervention.

COURT OF COMMON PLEAS,
COUNTY OF LUCAS
Toledo, OH, April 12, 1985.

Hon. GEORGE MILLER,
Chairman, Select Committee on Children, Youth, and Families, House of Representatives, House Office Building—Annex 2, Washington, DC.

DEAR CONGRESSMAN MILLER: Enclosed find my suggested corrected testimony. You will note that toward the end of the transcript I rambled needlessly and, therefore, I have stricken most of that testimony.

Concerning the two questions in your cover letter concerning the specific strategies and practices that we have developed to help parents deal with this problem, this is very difficult to do without making it a lengthy document.

We are in the process of putting such a document together and it should be ready within a couple of weeks. As soon as we have it, I will send you a copy. Suffice it to say at this time that our main strategy is simply to identify children who have a substance abuse problem and then to get that child help. We do this through our education program. Teachers are being trained to identify and work with parents; probation department's entire staff was heavily trained to identify and to know where help is available; parents through churches, schools, police, the Court, mental health agencies, are all being encouraged to identify and know where to get help.

If the child refuses help, parents are encouraged to bring the child to Court where we will, if necessary, detain the child in secure detention until the child is willing to accept the help available.

Parents were very reluctant at first to proceed this way, especially for young girls, fearing the harm and the record they would accumulate if charges were filed. That is no longer the case. There are enough parents out there now, literally hundreds and hundreds of them, who have been through the process and now can say that it was the best thing for their child. As many of them stated, "Our treatment really began with detention."

The Court works very closely with parent, child and hospital in the whole treatment process. Most children heavily on drugs will not accept treatment voluntarily. This is where our Parents Helping Parents organization has been so tremendously helpful. They can talk to parents with a great deal more success than the Court can. The whole process is so inter-woven that it is hard to separate the various strategies and practices.

The communication that takes place between parent, child, hospital, mental health, schools, Court, police, is all one continuing treatment process. Parents helping other parents will support them in bringing the child to Court. The Court works with parents to get the child into treatment. Treatment people work with the Court and the schools and parents treating the child. The schools developed a support system for the child when the child returns to school. Again, the Court, working with the child and the parent to return the child to school. It will overlap, not in duplicating any services, but simply everyone playing their role and supporting each other.

All of this will be more clearly understood when you see the entire document which we will send to you shortly.

Concerning funding, there was very little cash outlay during our first three years of existence. The Junior League contributed approximately $20,000 to help fund a secretary and coordinator. Everything else was volunteer or in-kind service or contribution. For example, the Lucas County school system donated the space, the telephone and the desk, Parents Helping Parents was fully a volunteer organization as were all of the committees. In the last couple of years the school system has paid for a full time coordinator, the Court has contributed some of its State subsidy money, the United Way has substantially funded Parents Helping Parents for a fulltime secretary, private corporations have made contributions in-kind and in cash and many organizations are now conducting fund raising actitivies.

Our budget for 1985 is $48,000 (schools, $12,000, Junior League, $16,000, Court $20,000.

I know that Congress is having a severe budgetary problem but it seems to me, because of the importance of this whole subject, that a certain portion of money that is presently being allocated to the States should be earmarked for programs in this area.

If you have any further questions please contact me. I'll do my best to get more complete information to you shortly. I am enclosing a document prepared by Blue Cross/Blue Shield for Parents Helping Parents application to United Way for funding.

Sincerely yours,

ANDY DEVINE, *Judge*.

Chairman MILLER. Next the committee will hear from Dr. Sheila B. Blume, M.D., medical director, Alcoholism and Compulsive Gambling Programs, South Oaks Hospital, Amityville, NY, and member, board of directors, Children of Alcoholics Foundation, Inc., New York, NY; John Daigle, vice chairperson, Governor's Commission on Drug and Alcohol Concerns; executive director, Florida Alcohol and Drug Abuse Association, Tallahasse, FL; John Bland, director, Alcoholism Control Administration, Department of Health and

Mental Hygiene, Baltimore, MD; and Carolyn Burns, vice president, programs, National Federation of Parents for Drug-Free Youth, Silver Spring, MD.

Let me tell you the situation we are in and you can make the choices you wish.

I have been handed a note that says the Armed Services Committee will come in here at 2 o'clock. We have to be out of here at 1:45. I'm sorry, I was not aware of this. I don't apologize for the time the committee has taken with the previous panels because I think it has been wonderful. I just wish we had more time with you, as well.

Proceed in the manner you are most comfortable with and we will withhold our questions so that you can each have an adequate time to impart your knowledge to us.

If there is time, we will ask questions. If not, the members of the committee will clearly have the opportunity to submit questions to you in writing.

My apologies that we get jammed up like this.

So, Dr. Blume, do you want to start?

STATEMENT OF SHEILA B. BLUME, M.D., MEDICAL DIRECTOR, ALCOHOLISM AND COMPULSIVE GAMBLING PROGRAMS, AND MEMBER OF THE BOARD OF DIRECTORS, CHILDREN OF ALCOHOLICS FOUNDATION, INC.

Dr. Blume. I am Sheila Blume, as you mentioned, medical director of the Alcoholism and Compulsive Gambling Program at South Oaks Hospital, on the board of the Children of Alcoholics Foundation. I wear many hats. I am on the board of directors of the National Council on Alcoholism; past president of the American Medical Society on Alcoholism; I was once New York State commissioner for alcoholism, and I am a clinical professor of psychiatry at State University of Stoneybrook.

I guess what qualifies me most is I have been a practicing psychiatrist for 23 years specializing in alcoholism. I have had a lot of time to see the kinds of effects alcohol and alcohol problems have on families.

I will handle the time problem by giving you all a reading assignment. I submitted with my testimony these two books which were prepared by the Children of Alcoholics Foundation. I had the privilege of being project director last year for the Conference on Research Needs and Opportunities for Children of Alcoholic Parents sponsored by the Children of Alcoholics Foundation.

At that conference, we assembled 18 leaders in clinical medicine and research. We reviewed the entire literature on children of alcoholics and effects of alcohol on families. We distilled what we thought were the most important research findings and research agendas, and we got together and tried to decide: What are the priorities? What strategies could we suggest for interesting people outside of the alcoholism field in getting involved in this work?

The two books are the conference report (the orange book), and the literature review (the blue book) which covers many of the questions that were asked about and discussed today.

What I would like to do is submit the written testimony and comment on some of the things I have heard today. The first panel was very touching. I could give a whole course to my students based on those case histories you heard this morning. They illustrated nearly every important point about alcoholism in men and in women, especially multigenerational aspects.

You heard about learning disabilities in the son of one of the alcoholics, Bret's older brother. This is a very common thing in children of alcoholics.

You heard about the woman who had been given Valium and didn't think she drank so much because she substituted Valium for alcohol and balanced the two, and might not have been picked up as an alcoholic by a physician who looked only at how much she drank.

You heard of her "walking into walls" and still not being picked up on her job because employee assistance programs are not sufficiently geared to pick up drug-related problems, and when they do, they often don't pick up women. We could do a course on that.

The cases you heard are typical, except for one thing: The people you met today all had the advantage of treatment. In every case, it was the treatment that turned their lives around. That is not typical.

The highest estimate of the number of people who need this help in America today and are receiving it is something like 20 percent. The truth is probably more like 5 or 10 percent.

Treatment facilities are not there for everybody who needs them. Help is not widely available. Even the facilities that exist, in the name of cost control, have been squeezed and squeezed down in length of stay and in the amount of treatment they can give.

You heard Bret say that on the 30th day of treatment, he "saw the light" and became motivated. You heard Judge Kramer say that he sent people to 28-day programs. If Bret had been in a 28-day program, he wouldn't be with us today; he would have been discharged before he developed motivation.

There has been a squeeze to do everything faster and reduce treatment to a mold. It can't be done that way, especially with young people. So I would like to bring this point to your attention as you look at alcohol in the family.

You heard about alcoholism running in families and its hereditary aspects, and there is more information on this in the publications. But I would like to talk about something that has not yet been discussed. You see my "Stop FAS" button; refers to Fetal Alcohol Syndrome, the effects of alcohol on the unborn. Fetal Alcohol Syndrome, is a lifetime disability which includes of growth retardation, both before and after birth; and most important, mental retardation and other central nervous system problems like poor coordination and hyperactivity; and also a characteristic facial appearance, and other birth defects. FAS is now known to be the third most common cause of mental retardation associated with birth defect in America today. Of those first three causes, which are Down's Syndrome, Spina Bifida, and Fetal Alcohol Syndrome, FAS is the only one that is entirely preventable. It is not being prevented adequately at this time.

HHS estimates that about 1,800 to 2,400 lifetime disabled infants have been born every year with FAS.

Adequate prevention of FAS means four things: First, adequate public information, not mixed messages, as Dr. Macdonald said. As far as we know today there is no safe level of alcohol use during pregnancy. There was a study in the JAMA last October that showed even one or two drinks a day during pregnancy significantly increased the chance of a low-birth weight infant.

Next we need professional information, and most importantly, the development of a good system to screen pregnant women at the first prenatal visit for alcohol problems. Finally we need to provide treatment to those who need it and to their families. Merely telling her that she shouldn't drink will not stop a woman with severe problems, who is most likely to produce the severe defect.

Let me say one last thing. We at the Foundation got together and conferred about research needs and strategies, and we agree that there is a lot that needs to be done.

We are, in many areas on the verge of learning keys, that will unlock the secrets of prevention of serious problems in alcoholic families. We were able to come up with an estimate that one of eight Americans is a child of an alcoholic.

But we don't have to wait for research to come through with more answers. We know enough already to justify a major effort to educate the health professions and the public.

We must educate decisionmakers Federal, State and local and private and public. We have to alert teachers and counselors, social workers, doctors, lawyers, health professionals, to identify the children of alcoholics that they encounter, to intervene with the family if it can be done, but even if the parents refuse treatment to bring help to that child, because the child of the alcoholic can be helped at any age, at any stage. That is my message.

Chairman MILLER. Thank you.

[Prepared statement of Sheila B. Blume, M.D., follows:]

PREPARED STATEMENT OF SHEILA B. BLUME, M.D., MEDICAL DIRECTOR OF ALCOHOLISM—COMPULSIVE GAMBLING PROGRAMS AT SOUTH OAKS HOSPITAL, AMITYVILLE, NY

Thank you for the opportunity to testify this morning about this most important subject. I am Sheila B. Blume, M.D., medical director of Alcoholism and Compulsive Gambling Programs at South Oaks Hospital, Amityville, New York, member of the board of directors of the Children of Alcoholics Foundation in New York City, former director of the New York State Division of Alcoholism and Alcohol Abuse, member of the board of directors (and former medical director) of the National Council on Alcoholism and a past president of the American Medical Society of Alcoholism.

I am a psychiatrist who has specialized in the field of alcoholism for the past 23 years, and have had ample opportunity to observe, first hand, the devastating effect of alcoholism on family members.

Last spring I had the privilege of acting as project director for a conference on research needs an opportunities for children of alcoholics sponsored by the children of Alcoholics Foundation. This conference brought together 18 leaders in clinical medicine and research to review current knowledge about the effects of alcoholism on the family, identify priority research needs and opportunities and recommend strategies for encouraging such research. The report of that conference is submitted with this testimony, and additional copies are available from the foundation. A review of the research literature for the conference by Dr. Marcia Russell, Cynthia Henderson and myself, has also been published and is submitted with this testimony. My comments on the family derive largely from this review.

Alcoholism touches many American families. Dr. Russell estimated, using available national survey data from 1979 and population data from 1980, that in excess of 28,000,000 Americans are the offspring of problem-drinking parents, or one out of every eight Americans. Of these about 22,000,000 are adults and another 6,600,000 are children below the age of 18.

Research over the past 15 years has clearly demonstrated that alcoholism is a disease that runs in families. Further research on identical and fraternal twins, half-siblings from alcoholic families, and children adopted away from their biologic parents early in life, all point to a heriditary predisposition to alcoholism. That is not to say that the disease is inherited. Rather, each individual's genetic constitution can be placed somewhere on a continuum between relative protection from, and relative predisposition to alcoholism. Influences from the environment are also important. These include psychological stress and methods each individual learns to cope with life stresses. Also important are personal values, social customs and public policies, all of which are influence on the individual's exposure to alcohol.

This research has begun to point the way toward effective prevention of alcoholism. Programs that are targetted at the group at highest risk, and that focus on key environmental factors that can be influenced, will have the highest yield. As of now, we can only say that the children of alcoholics are at highest general risk, but current research on this group has developed leads that might yield a biological marker for those children of alcoholics most specifically at risk. First, for example, Dr. Henri Begleiter, of Downstate Medical Center in Brooklyn, New York, has found characteristic brain wave patterns in the electroencephalograms of a subgroup of sons of alcoholic fathers who themselves had never been personally exposed to alcohol. Secondly, other differences between sons of alcoholic parents and those with no alcoholic family history have been found by Dr. Marc Schuckit of the University of California at San Diego and his colleagues. These include higher postdrinking levels of the blood chemical acetaldehyde, lower levels of muscle tension and less pronounced subjective feelings of alcohol effects.

Not only have leads developed to uncover inherited factors in alcoholism, but research has also provided evidence for familial links between alcoholism and depression, especially in female relatives of alcoholics, attention deficit disorder (childhood hyperactivity), and possibly other psychiatric disorders.

In addition to hereditary and familial influences on children in alcoholic families, there is another important negative factor which has been the focus of recent research. I refer to the direct toxic effects of alcohol consumed during pregnancy, often by an alcoholic mother, on the developing fetus. Of all causes of mental retardation due to birth defects in the United States, the Fetal Alcohol Syndrome [FAS] is currently the third most common. Of these three most frequent causes (down's syndrome, spina bifida and FAS) only FAS is totally preventable. There are an estimated 1,800 to 2,400 infants born disabled by FAS each year. In addition, a far larger number of infants are born annually suffering from Fetal Alcohol Effects [FAE]: growth deficiencies and other birth defects related to maternal alcohol intake which do not have the full compliment of defects that characterize FAS.

Recent research has sought to understand how alcohol produces this damage, what levels of alcohol intake (if any) might be considered safe during pregnancy and what biological characteristics protect some fetuses from harm. Much more is needed. Additional studies are also needed to determine the best methods for preventing FAS and FAE: for educating the public, for screening women of childbearing age for alcohol problems and for assuring that they get the help they need to recover.

Research on alcohol and the family has also centered on a wide range of problems encountered by the children of alcoholics, such as child abuse and neglect, social isolation, conduct and learning disorders, drug abuse, suicidal tendencies, and somatic complaints (e.g., headaches and stomach disorders). In clinical studies, all of these problems have been shown to be associated with parental alcoholism. A better understanding of the dynamics of the alcoholic family will most likely improve our ability to prevent these tragic consequences. However, enough is already known to justify a major effort to educate those in the helping professions on Federal, State and local levels, and in both the public and private sectors.

We must prepare physicians, nurses, teachers, counselors, social workers, lawyers, psychologists, probation officers, judges and corrections experts, to identify those in their caseloads who are children of alcoholics or members of alcoholic families; to take action wherever possible to bring help to the family system; but most importantly, the child should be the main focus regardless of the willingness of the parents to enter treatment for alcoholism. Children of alcoholics can be helped, at any age. That is our most important message.

That is the focus of the Children of Alcoholics Foundation, a voluntary, nonprofit public foundation, established in response to public interest and the Nation's first Governor's Conference on Children of Alcoholics, held in New York City in October 1982. The goals of the foundation are to increase public awareness of the unique problems of these vulnerable youngsters; to promote research and disseminate research findings; and to encourage local, State, Federal and other agencies to respond to the special needs of these youngsters. Through its program and projects, the foundation is working to help break the vicious cycle of family alcoholism, and is delighted to share the results of its research conference with the committee.

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, DC, April 3, 1985.

SHEILA BLUME, M.D.
Director, Alcoholism and Compulsive Gambling Programs,
South Oaks Hospital,
Amityville, NY.

DEAR DR. BLUME: This is to express our personal appreciation for your appearance before the Select Committee on Children, Youth, and Families at our hearing, "Alcohol Abuse and Its Implications for Families," held here in Washington, March 18. Your participation contributed greatly toward making the hearing a success.

The Committee is now in the process of preparing the transcript of the hearing for publication. It would be helpful if you would go over the enclosed copy of your testimony to make sure that it is accurate, and return it to us within three days with any necessary corrections.

Also, we would greatly appreciate your answering the following for the record:

Based on your experience in the field and given the multidimensional causation and host of problems related to alcohol abuse and alcoholism, how might we best deploy limited resources to address the problems effectively?

Let us again express our thanks, and that of the other members of the Select Committee for your testimony.

Sincerely,

GEORGE MILLER,
Chairman, Select Committee on Children, Youth, and Families.
WILLIAM LEHMAN,
Chairman, Task Force on Prevention Strategies.
LINDY (MRS. HALE) BOGGS,
Chairman, Task Force on Crisis Intervention.

SOUTH OAKS HOSPITAL,
Amityville, NY, April 10, 1985.

Congressman GEORGE MILLER,
House of Representatives, Chairman, Select Committee on Children, Youth, and Families, House Office Building, Annex 2, Washington, DC.

DEAR CONGRESSMAN MILLER: I enclose the corrected transcript of my remarks. The answer I would offer to your most provocative questions is as follows:

1. The Congress can provide leadership in focusing on problems of alcohol in the family and children of alcoholic parents. These hearings should be followed up by meetings, public information material and other measures to raise awareness.

2. Funds are desperately needed for increased research in this field. The Children of Alcoholics Foundation conference identified important leads that could help prevent costly problems. Alcohol abuse alone costs is $120 billion a year. Preventing even a small fraction of these problems will far outweigh the cost of research. The human suffering saved cannot be calculated.

3. More funds and programs are needed for training: young scientists to work on alcohol/family issues; clinicians of all disciplines in treating the alcoholic family; teachers, school criminal justice personnel and others. Public/private partnership efforts could very well accomplish some of this goal.

4. Prevention strategies which are part of an overall comprehensive and coordinated national alcohol policy such as that developed by the American Assembly of Columbia University in May of 1984 are needed. Congress has responsibility for ingredient and warning labels on beverages, taxation, advertising and other measures which influence the availability and glamorization of alcoholic beverages. Congress

has already acted on the subject of minimum purchase age for alcoholic beverages. There are many other measures awaiting action.

I enclose a copy of the American Assembly publication, which I believe should be made known to all decision makers and the public.

Thank you for your genuine and continuing concern for the millions of suffering alcoholics in America and for their families.

Yours sincerely,

SHEILA B. BLUME, M.D.,
Director, Alcoholism and Compulsive Gambling Programs.

THE NATIONAL COUNCIL
ON ALCOHOLISM'S

PREVENTION POSITION STATEMENT

NATIONAL COUNCIL on ALCOHOLISM Inc.

SUMMARY

The National Council on Alcoholism announces the adoption of a Prevention Position Statement on alcoholism and alcohol-related problems. In addition to education and information programs, NCA supports the following measures:

- Curbs on advertising of all alcoholic beverages, including the voluntary elimination of radio and T.V. advertising, and intermediate measures, such as the establishment and enforcement of national standards for radio, T.V. and print advertising which eliminate use of young people, athletes, persons engaging in risky activities and sexual innuendo.
- Counter advertising, through paid and public advertising, including health warnings about alcoholism and alcohol-related problems.
- Adjusting taxes on beer and wine to equal those for distilled spirits, and adjusting taxes on all alcoholic beverages for inflation experienced since 1951.
- Establishment of a national legal age of purchase of 21 years for all alcoholic beverages.
- Requirement that alcoholic beverage containers display all ingredients and alcoholic content by volume, in addition to a rotating series of health warning notices on:

  drinking and driving
  drinking and pregnancy
  alcohol and drug interactions
  links of excessive alcohol use to health-related disorders, including alcoholism, cirrhosis, heart disease and cancer.

TEXT

The National Council on Alcoholism has worked for more than forty years to erase the stigma associated with alcoholism, and to educate the public about this treatable—and beatable—disease. And we have had tremendous success.

Forty years ago, who would have imagined that today there would be broad recognition throughout the world that alcoholism is treatable; that there would be over 5,000 treatment units throughout the United States, and more than 42,000 identifiable groups of Alcoholics Anonymous worldwide, all helping millions of people to a new life of recovery.

These accomplishments are the result of hard work by all of us—volunteers in industry, in the medical and scientific communities, in our schools and communities—and they are accomplishments in which we as an organization have played a critical role, and of which we can be proud.

This is the past, and it is an important part of our future. But an equally important part of our future is to respond to growing public awareness about alcohol-related problems which has occurred as a natural evolution of our work on the disease of alcoholism.

As the National Research Council on the National Academy of Sciences has observed:

> "The alcohol problem is more than what the standard view of 'alcoholism' suggests, because it affects many more of us than we are accustomed to believing. . . . (it may have) to do with how alcohol is fitted into daily life and the external environment."

Today's environment is permeated by over a billion dollars of advertising which either directly or indirectly encourages the consumption of alcoholic beverages, and has promoted positive messages about alcohol use in the arts, the media and society as a whole. Drinking is associated with the 'good life', with health, with success, and with sexuality.

In addition, this has been matched by a general trend of relaxation of controls on availability and price of alcoholic beverages which has, in turn, been followed by steady and frightening increases in alcohol-related problems, especially among young people and in the workplace throughout the country.

Alcohol problems are so widespread that they cannot be effectively approached except through broad, general prevention measures. Problems of this magnitude affect not just particular groups of Americans, but affect nearly every American.

The National Council on Alcoholism can be a vital public force in the coming decade by providing information to counter the growing public perception that drinking alcohol is a healthy and even safe thing to do. To do this, NCA must add to its existing priorities for research, public policy, treatment and education, bold new stances to the prevention of alcohol problems.

The following position statements on alcohol advertising, taxation, labelling, and legal purchase age are such bold policies. These actions, in combination with education and information programs, can begin to make inroads in the enormous alcohol problem facing our country today. Singly, none of these actions would be as effective as if they are implemented together as a unified prevention strategy. Working in unison, they are an effective prevention tool to combat the rise in alcohol-related problems and alcoholism we have experienced in recent years.

ADVERTISING

NCA is concerned over recent linkages between alcoholic beverage advertising and the reported increase in alcohol consumption among young people. Alcohol consumption is associated with a range of health and societal problems including alcoholism, cancer, heart and liver disease, family violence, career dissolution, economic loss due to job absence and sickness, crime and accidents. For young people, it is especially associated with alcohol-related highway fatalities, and school, familial and developmental disruption.

Because young people are a major audience, NCA believes the alcoholic beverage industry should voluntarily discontinue advertising their products on television and radio. As an intermediate step, NCA supports:

A. The voluntary elimination of misleading and inappropriate advertising in the T.V., radio and print media, and the stricter enforcement of false advertising laws. In particular, we refer to:
    1. The use of young people (and young looking people) in advertising.
    2. The use of current or former athletes in advertising.
    3. The use of people engaging in sports activities or risky situations in association with or while drinking.
    4. The use of advertising suggesting sexual, business or social success accrues to alcoholic beverage consumers.

B. The requirement that all alcoholic beverage advertising contain rotating health and safety warning notices.

C. The allowance of equal time for counter-advertising on the health risks of alcohol consumption when beer or wine ads appear on television.

TAXATION

Federal taxes on alcoholic beverages have not been raised in over thirty years. This has led to a substantial reduction in the price of alcoholic beverages relative to other commodities and has exacerbated drinking problems. Yet, studies now show evidence that raising taxes on alcoholic beverages reduces the quantity of consumption of the beverages, as well as deaths due to cirrhosis of the liver and highway fatalities.

Currently, liquor is taxed more heavily than beer or wine, based on the erroneous notion that it is the most harmful beverage. Since research cannot find differences among the effects of beverage types, NCA believes that the tax on beer and wine should be raised to equal the tax on distilled spirits and that the tax should be adjusted for inflation since 1951.

LEGAL PURCHASE AGE

NCA deplores the carnage on the nation's highways due to teenage drinking and driving. Alcohol-related motor vehicle accidents are the leading cause of death among young people. Because as a group, 18-20 year olds are inordinately represented in alcohol-related accidents and because research now indicates that raising the minimum drinking age significantly reduces alcohol-related crash involvement among young drivers, the National Council on Alcoholism urges Congress to adopt a national legal age of 21 for the purchase of alcoholic beverages.

LABELLING

Because of the overwhelming evidence that the consumption of alcohol can lead to serious health problems, including alcoholism, birth defects, and cancer, and because it believes in the public's right to know, the National Council on Alcoholism supports requiring specific health and safety warning labels as well as information on ingredients, calories and alcohol content by volume on alcoholic beverage containers.

Specific warnings on alcoholic beverage containers should be part of a rotating series of notices and address such areas as: alcoholism, the illegality of driving under the influence of alcohol, cirrhosis, cancer, FAS, and alcohol and drug interactions.

Chairman Miller. John Daigle.

STATEMENT OF JOHN DAIGLE, VICE CHAIRPERSON, GOVERNOR'S COMMISSION ON DRUG AND ALCOHOL CONCERNS, AND EXECUTIVE DIRECTOR, FLORIDA ALCOHOL AND DRUG ABUSE ASSOCIATION

Mr. Daigle. Thank you, Mr. Chairman.

My name is John Daigle, executive director of the Florida Alcohol and Drug Abuse Association. Our association is composed of the alcohol and drug abuse provider agencies in Florida.

Today it is my pleasure to represent Florida's Governor, Bob Graham, and the Governor's Commission on Drug and Alcohol Concerns.

Given the circumstances and guidelines regarding our testimony, I will try to cut back significantly. You have a copy of my comments as well.

The major reason I am here concerns the Governor's commission report, which I believe the staff has distributed to all of you. That really is the substance of what Florida has to present to you.

Florida's Governor has consistently recognized the abuse of alcohol and drugs by our citizens as one of the most serious problems facing our State and a problem that could only be addressed through the active involvement of all Florida's citizens, as you have heard today.

The Governor's campaign against substance abuse has included aggressive initiatives to strengthen Florida's drunk driving laws, increase enforcement and strengthen social controls regarding alcohol and illicit drug use.

Most importantly, however, Governor Graham has recognized that in order to meet the challenge, both enforcement issues and the demand for substances must be addressed.

As a result of that concern, in March, Governor Graham established what he believes is a strong statewide participation to attack substance abuse problems. Within this effort, he called on those representing parents, law enforcement, religious, State and local policymakers, treatment professionals, and private industry to become actively involved in the development of a comprehensive coordinated approach to alcohol related problems.

We felt it significant that the industry was represented, for example, by vice presidents of Eastern Airlines and IBM, and they played a major role in the product we are able to present to you today.

Basically, in looking at the problems of substance abuse in Florida today, the commission held a number of hearings around the State, addressed a number of issues in three major areas, prevention education, early intervention, and treatment.

And we developed a number of recommendations relative to those three areas. In prevention education, the commission felt those really were the cornerstone of any efforts to reduce alcohol abuse.

Students in Florida indicated a high rate of exposure to illegal drugs and alcohol as early as the fourth grade. Large numbers of Florida's youth regularly drink alcohol to excess.

As you heard earlier, it was concluded that the family places a very important part of any recovery process and is a significant part of the problem.

Basically, some of the recommendations regarding prevention included recommendations that there be mandatory comprehensive prevention and education programs in all Florida schools.

Second, that schools develop specific well-defined policies regarding the use of alcohol and other substances.

Three, that the States support the expansion of States and local informed parents organizations which have been very effective at the community level.

Also, the commission recommended development of abuse prevention programs on all college and university campuses in Florida. Many universities and colleges already have the BACK-US Program, which has been very effective, and this is something that the commission felt should be really encouraged and supported in those which did not have a program.

The basic philosophy regarding prevention, of the commission, was that any approach needed to be comprehensive in nature. We could not pick out one program that would be the golden egg, the solution, but it is really necessary to address it in some comprehensive fashion.

One of the areas of specific interest that the commission analyzed was a special high-risk population, that is, Florida's elderly. In 1981, there were over 1.7 million elderly Floridians over 65 and they represented over 17 percent of Florida's population.

One of the most prevalent problems facing this elderly population is the problem of alcohol and drug misuse. Some of the recommendations regarding drug misuse among the elderly was development of a systematic program for drug education services for the elderly in health care and social service settings as well as increased opportunities for timely recognition and treatment of drug misuse among the elderly.

The second major area we looked at was early intervention. This is something that I think you have heard stated many times today, that it is critical to increase our focus in the area of identifying individuals early on in the process of alcoholism and alcohol abuse.

There are, as Dr. Blume has referred to, there are thousands of families unlike those families you heard testify who are undergoing the pain and suffering without the benefits of treatment. And many of those families will continue for years, if not forever, without ending up with that treatment.

Even the most resourceful families who may have a problem really don't know where to turn, don't know where to confront the individual, and we really felt that a major thrust of the commission's recommendations should focus on providing, making accessible that service of intervention in many communities throughout Florida.

Finally, the commission also looked at the treatment system in Florida. Basically, there are an estimated 46,000 clients who go through treatment in Florida each year. And it was felt there was a considerable need for increased treatment, detoxification services, specialized services for youth, specialized programs for the mentally ill substance abusers as well as minorities.

If you are to put in place early intervention programs, obviously it is critical to have the resources there to treat those that do enter treatment.

Finally, the commission recognized that, as has been stated already, it was very important to expand the knowledge surrounding the cause of alcoholism, ways of reducing suffering.

Research is something that became a priority of the commission. It is the intent that Florida establish a center of excellence that would coordinate research and training efforts in the area of alcoholism treatment and prevention.

Many of the recommendations that the commission came up with cannot be implemented immediately. I think one of our learnings is that just as the problem is an extremely complex one, so the solutions are complex, and hopefully our commission will continue over a number of years to address those problems.

However, our message is one of optimism. Alcoholism is treatable. There are answers that have been found, prevention programs that have been found to be effective.

We commend you and your efforts that you are making in this area, and appreciate the opportunity to share Florida's program with you.

Thank you.

Chairman MILLER. Thank you.

[Prepared statement of John Daigle follows:]

PREPARED STATEMENT OF JOHN G. DAIGLE, EXECUTIVE DIRECTOR, FLORIDA ALCOHOL AND DRUG ABUSE ASSOCIATION, TALLAHASSEE, FL

Mr. Chairman, Members of the Joint Committee, ladies and gentlemen, my name is John Daigle, executive director of the Florida Alcohol and Drug Abuse Association. Our association is composed of the alcohol and drug abuse provider agencies in Florida. Today it is my pleasure to represent Florida's Governor, Bob Graham, and the Governor's Commission on Drug and Alcohol Concerns.

Florida's Governor has consistently recognized the abuse of alcohol and drugs by our citizens as one of the most serious problems facing our state and a problem that could only be addressed through the active involvement of all Florida's citizens.

The Governor's campaign against substance abuse has included aggressive initiatives to strengthen Florida's drunk driving laws, increase enforcement and strengthen social controls regarding alcohol and illicit drug use. Most importantly, however, Governor Graham has recognized that in order to meet the challenge, both enforcement issues and the demand for substances must be addressed.

Alcoholism within our State costs Floridians billions of dollars each year and the cost in human suffering to individuals of every age, race and income is incalculable: 33 percent of all reported child abuse cases in Florida are substance abuse related; 52 percent of all homicides this year were directly related to alcohol; and 56 percent of all family violence was alcohol related.

The cost to Florida's economy is estimated to be $2.5 billion for alcohol abuse.

In order to respond to the large numbers of citizens and families who are suffering the direct or indirect effects of alcohol abuse, the Governor has established a statewide partnership to attack our substance abuse problems.

Within this effort, the Governor called upon citizens representing parents, law enforcement, religious, State and local policymakers, treatment professionals and private industry to become actively involved in the development of a comprehensive coordinated approach to alcohol related problems. During March 1984, the Governor appointed members of the Governor's Commission on Drug and Alcohol Concerns. This 22 member commission serves as the focus of Florida's efforts in our development of a statewide approach to prevention, education, early intervention, and treatment needs.

Florida's program of reducing alcoholism and its impact on our State is targeted at every segment of our communities, every family, and every business to bring alcohol abuse awareness to all citizens and motivate them to become active participants in the fight against alcoholism. At the heart of this concept is an understanding that community and State efforts are most successful when they attack the full range of problems caused by alcoholism. Family violence, crime, illness, and costs due to lost productivity must all be considered in any comprehensive effort.

The goals of the commission include:

To provide a coordinated and comprehensive program of substance abuse prevention and education in Florida;

To establish statewide policies and promote strategies and actions that may be used by both the public and private sectors to combat substance abuse;

To establish partnerships among community, business and government leaders to facilitate a comprehensive approach to substance abuse; and

To increase public awareness regarding alcohol and drugs and the effects of their use and abuse.

During the past year, the Governor's commission activities have included initiatives on the State, regional, and national level. Additionally, public hearings were held throughout Florida to solicit the direct participation of all our citizens. As a result of the commission efforts, during the first nine months of existence, the commission has completed its first report, "reducing the demand: Florida's partnership for substance abuse prevention, intervention and treatment." Retained in committee files. This 106 page report establishes major policy issues and makes specific recommendations regarding our State's needs of families for prevention, early intervention and treatment for alcohol and drug related problems.

As our statistics have indicated, Florida's families are severely impacted by alcohol and its effects. Our youth, their parents and their grandparents face the consequences of alcohol abuse daily.

Three areas that are most vital to Florida's efforts include programs of prevention and education, early intervention and treatment.

Alcohol abuse prevention and education activities are the cornerstone of Florida's efforts in the reduction of alcohol abuse. Florida's partnership for alcoholism prevention includes policies and strategies designed to prevent abuse among all segments of our population with particular emphasis on our youth and their families.

Our students in Florida indicate a high rate of exposure to illegal drugs and alcohol as early as the fourth grade.

Large numbers of Florida's youth regularly drink alcohol to excess.

When a family member is affected by alcohol, the entire family becomes a part of the illness and must be a significant part of recovery.

To address the prevention needs of our youth and their immediate family members, the commission advocates:

Mandatory comprehensive prevention and education programs in grades K-12 in all Florida schools;

The development of specific well-defined policies regarding the use of alcohol on school grounds;

The expansion of State and local informed parents organizations;

The development of alcohol abuse prevention programs on all college and university campuses; and

Increasing involvement of Florida's youth in all prevention efforts.

Florida's large elderly population comprises a special high-risk group of citizens for drug and alcohol use and abuse. In 1981, there were over 1.7 million elderly Floridians over age 65 representing 17.8 percent of the State's population. One of the most prevalent problems facing the elderly in our State is the problem of drug misuse.

Policy and strategy recommendations responding to drug misuse prevention among the elderly include:

The development of a systematic program for drug education services for the elderly in health care and social service settings.

Increase opportunities for timely recognition and treatment of drug misuse among the elderly.

Early intervention programs provide a community response through the recognition of and assistance to our citizens who have used or are currently using alcohol. Increased training and education of professional in alcohol abuse recognition, the early evaluation and assessment of family members in early stages of abuse and the establishment of community-based early intervention programs all serve to identify abusers and assist in preventing further abuse.

Policy and strategy recommendations respond to Florida's early intervention needs by advocating:

The expansion of school-based early intervention programs for our youth; and

Comprehensive training of Florida's health care professionals, educators, attorneys and law enforcement personnel in the recognition and referral of substance abusers.

In attempting to develop a statewide, comprehensive campaign against alcohol abuse, the governor's commission recognized that an examination of Florida's system of treatment services for those citizens currently suffering the consequence of alcoholism was necessary.

There are an estimated 520,000 alcoholics in Florida. Thirty-nine public alcoholism treatment centers served 46,683 clients during 1984–85. The needs for increased services for drug and alcohol detoxification, domiciliary services for alcoholics, specialized services for drug abusing youth, mentally ill substance abusers and minorities were reviewed by the commission.

Policy and strategy recommendations responding to the treatment of needs of alcohol abusers in Florida include:

Developing comprehensive services for families requiring treatment and care;

Coordinating State and local planning for treatment services;

Reviewing and improving evaluation and assessment capabilities in Florida;

Encouraging the developing of successful drug and alcohol treatment programs through allocations of additional resources based on well-defined needs and priorities;

Upgrading and improving general licensure and quality of care;

Encouraging private industry, civic and community organizations, parents law enforcement and State and local agencies to provide support for treatment programs; and

Recognizing the need for "family oriented" treatment.

Finally the Governor's Commission recognizes that in order to eliminate alcohol abuse in Florida, the State must continue to expand its knowledge of the causes of alcoholism and ways of reducing human suffering and the enormous costs to our State. Research and data collection efforts should reinforce all programs and provide a valuable component in Florida's system or prevention, early intervention, and treatment.

The Governor's Commission notes that many of the recommendations contained within the report cannot be implemented immediately. Some require future study and consideration at the State and local level. The ability of our State to be successful in this endeavor depends upon the commitment and active involvement of all Florida's citizens.

I commend your efforts on behalf of families throughout our State, and once again thank you for this opportunity to share Florida's program with you.

Working together, we can provide an effective attack on our substance abuse problem throughout our State and Nation.

Chairman MILLER. John Bland.

STATEMENT OF JOHN BLAND, DIRECTOR, ALCOHOLISM CONTROL ADMINISTRATION, DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Mr. BLAND. Thank you, Mr. Chairman.

Mr. Chairman, members of the select committee, I am John Bland, director of the Alcoholism Control Administration, and representing also Ms. Adele Wilzack, secretary for the Department of Mental Hygiene in Maryland.

In keeping with the lateness of the hour, I will not read my testimony, but pick up what I consider to be several important points.

I think there are two major points that we should bear in mind as I attempt to articulate the Maryland treatment experience. One is that we are attempting to provide comprehensive care and treatment involving the family and/or parent surrogates at each level of treatment.

I wish to point out that, as we have heard from the models of Judge Kramer and from Judge Devine, we also in Maryland have a model fitting the same context and that is the work of Judge

Daniel Moyland in Washington County, and the community of Hagerstown, which is the largest town.

Judge Moyland is significant in this process in light of the fact that for about 10 years, Maryland Alcoholism Treatment Program has focused essentially on carrying out the legislative mandate by providing comprehensive services to adult alcoholics.

It has only been within the last 2 years under the direction of Judge Moyland as he attempted to bring into existence a grant from, I believe, the Office of Juvenile Justice and Delinquency Prevention to provide comprehensive care to young people in his district. As a circuit court judge he handles all the juvenile cases.

With that particular grant, he engaged from the beginning not only the youngsters who were presented to him—and his data showed that better than 65 percent had alcohol and/or other substances as part of their problem—the grant was used to hire trained personnel to do community outreach as well as determining who the significant persons were, and in most instances, bringing them in to treatment at the point of disposition.

Therefore, parents who expressed any reluctance or resistance were under the dicta, if you will, of the judge, who in many instances had parents involved in treatment, particularly those parents who had histories of alcoholism and/or chronic alcohol abuse.

He has been extremely aggressive, Judge Moyland, in bringing to the attention of those who sit on the bench with many other districts the fact that in order to effectively address the 60-some thousand youngsters who cycle in and out of the Juvenile Service Administration on an annual basis, with approximately 65 percent of those youngsters having alcohol or alcohol abuse as a significant part of why they were in difficulty, whether on the basis of truancy, vandalism, questions must be raised regarding the role chemical abuse plays in the acting out behavior.

He is convinced—in some respects, more than those of us in the field—that there is a higher number of youthful alcoholics. He makes this point very, strongly. Some of us are somewhat reluctant on the basis of age as being a factor to place as heavy a label as youthful alcoholic. But Judge Moyland is very convinced.

And as a consequence, we began to, one, listen to his message; and two, to determine that he was also correct. That in order to address the issue of treatment for the entire family, it was absolutely essential that comprehensive care, from the acute phase, all the way through to the return to the community were important aspects of treatment.

To that extent, Maryland has established a system of identification, assessment, residential treatment, group homes for youngsters and outpatient care. Residential care must meet the criteria established by the State Health Planning Agency in order to ensure quality care as well as meet the requirements of third-party funders. This we have achieved.

You have heard some of the complications; for example, youngsters accessing intermediate care and being allowed to participate in intermediate care treatment for only 28 days. We believe very, very clearly that a length of stay that is appropriate for service to adolescent and youths to be about 60 days, and our general treatment protocol is an average length of stay of 45 days.

We think that categorically there is not sufficient life experiences that adolescents and youths can plug into which will allow them to creatively and appropriately understand the seriousness and complex nature of the disease with which they are struggling.

In addition, youngsters by definition, almost in terms of musculature and so on, expend a great deal of energy and therefore they need to have experiences that engage them in recreational therapy, a lot of time in the gym, and so on.

So the extent to which you can keep them busy in treatment, letting off steam, being involved in groups, individual treatment and so on, our experience has paralleled the Hazelden experience. We have sent staff to Hazelden who spent a week there and returned, and confirmed fairly well that the 60-day length of treatment as well as the bringing together of recreational services and in addition bringing to that experience educational services as well to assure that there is no break in the educational activities, is all very critical.

As we have looked at some of the experiences not only in our own State but around the country, we have learned that we are really talking about multiproblem families. And, therefore, the level of awareness, the level of training that the alcoholism counselors who traditionally worked with the adult, who are by and large those who could be detoxed within 3 or 4 days, some would have to go to an intermediate care from 14 to 28 days, with the ultimate goal depending on the age, if the individual were under 55, of moving back into society, picking up and becoming gainfully employed.

These are not the goals, obviously, for the adolescents and youths we are working with.

In most cases, the primary goal will be to assist the youngster in addressing some of the same problems we have heard dramatically presented to us today, to effectively be involved in a process of reintegration back into the family, if in fact there is a family; where there are parental surrogates, to begin to develop new ways of relating and helping them to be in closer contact with their feelings, and beginning to assist them in addressing some issues around values clarification.

So, when there is reintegration into the family it must be at a level at which these services and treatment supports will build upon so that there is a solid basis for recovery, not only for the youngster, but also for the family. And treatment assists the family so that all can positively participate in the recovery process.

Chairman MILLER. I will have to ask you to cut it short or, otherwise, we will leave one of our people out.

Mr. BLAND. I just want to be clear on the point that what I have said so far, by and large, shows a strategy for the individual where he is generally not struggling with parents who are alcoholic.

Where the parents are alcoholics, then what I would say is that we are melding the treatment criteria and protocols I have mentioned and even coercive treatment for either the parent who is the alcoholic, or in many cases, it is where both parents are alcoholics.

We want to insure that all of the elements supports in fact a positive basis for recovery not only on the part of the youngster but the parents as well.

Thank you.

Chairman MILLER. Thank you very much. My apologies again for the rush.

[Prepared statement of John Bland follows:]

PREPARED STATEMENT OF JOHN BLAND, DIRECTOR OF THE ALCOHOLISM CONTROL ADMINISTRATION, AN AGENCY WITHIN THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Mr. Chairman, members of the Select Committee and honored guests, my name is John Bland. I am the Director of the Alcoholism Control Administration, an agency within the Maryland Department of Health and Mental Hygiene. My brief comments will focus on the Maryland alcoholism treatment continuum as it relates to comprehensive care for adolescents and youths and their families. Two major points to bear in mind are comprehensive care and involvement of family or parental surrogate at each level of treatment.

In Maryland we are on the threshhold of completing the treatment continuum. Since the late 1960's our focus has been to target services to the adult alcoholics and problem drinkers. They have been perennially most visible and the basic assumption has been that once established on a good recovery track these adults can return to gainful employment, resume socially acceptable roles, e.g., parent, positive participant in family and community activities and many other functions. In recent years, however, the pendulum has been swinging back toward a clear recognition that alcohol abuse problems begin with our teenagers and youngsters.

Admittedly we live in a drinking society. Children mimic their parents and significant adults in their youthful alcohol misuse patterns. The longitudinal studies in Maryland have shown consistently over the years that alcohol is the most abused substance by our high school age youngsters. These studies cover more than a decade. Additionally, they illustrate boys to be heavier abusers and the tendency is toward the abuse of alcohol and other drugs. Cigarette smoking and peer activities are also concomitant factors in the patterns of abuse.

Another factor which we in Maryland deem to be extremely important and there is overwhelming support in the literature today is that children of alcoholics are very much at risk. Several of our local programs are developing major strategies to provide treatment for this high risk population. For example, having focused so much on the adults we now have a large population already identified who are in treatment, many in solid recovery, that is, a number of years of abstinence, who are now expressing concern about the teenagers who need treatment. Unfortunately, these are a small cohort because usually the pattern is one where in the parental drinking is still devastating in its impact on the non-drinking spouse and children, wherein there is a whirlwind of spousal and child abuse and neglect including incest associated with the alcoholic or problem drinker and recovery is still a goal to be achieved.

The latter multi-problem family scenario is the basis upon which our determination to provide treatment for the entire family rests. Frequently the youngster is referred by the Juvenile Services Administration based on his or her problems with school, family or community with alcohol abuse playing a prominent role. Yet on closer examination the young person's acting out is the peak of the iceberg with parental problems being of a significantly greater magnitude that no matter how much treatment is provided the youngster, no significant recovery pattern is going to be established for him or her until the entire family is in treatment. This is still a pertinent factor even if the young person is placed in a residential setting but eventually the goal is to return to their own home. That would be ludicrous and wasteful in our judgement if there is not significant effort to intervene in the family's pattern of behavior.

We have found alcohol abuse to be positively correlated with youthful acts of truancy, school and community vandalism, poor school performance, school drop out, adolescent pregnancy, suicide and suicidal gestures, auto accidents and deaths. Similarly, with adults the same pattern of incarceration, conflict with spouse and family, poor work performance, child abuse and generalized instability with alcohol abuse a major factor.

For the adult correctional system we are providing treatment services starting at the reception center in the penitentiary system, with AA and NA as stabilizing activities during the bulk of the period of incarceration and again providing intense treatment of 12 weeks prior to pre-release for alcoholics and alcohol abusers and 26 weeks for heroin addicts. The latter phase involves the family in treatment where-ever practicable and case management services to insure that when the inmate and family are reunited success is built in rather than setting both the ex-offender and family up for another failure, thus enhancing the alienation and hostility.

During the past 2 years as a major Gubernatorial Initiative, we in Maryland have been engaged in a vigorous campaign to stop the drunken driver from maiming and killing motorists and pedestrians. We require DWI or DUI offenders who are assessed as problem drinkers or alcoholics to remain in treatment for a minimum of 6 months. With the District Court judges concurrence wherever there is an intact family, every effort is made to bring the family into treatment. Intervention is generally at an earlier age for DWI offenders. The individual is normally gainfully employed, married and has children. To many of our treatment providers this marks a dramatic shift in treatment strategies insofar as there are many more resources to work with than is the case with the more chronic and completely dislocated older alcoholic. Alcoholism and alcohol abuse are devastating in their impact on the family. Treating the whole family rather than one or two members increasingly is making good clinical sense to our counselors throughout the state. I am commiting significant resources to train our treatment personnel to enable them to evaluate and then provide family counseling and therapy.

I have described briefly services to adult population in the criminal justice system and DWI/DUI referrals. I will spend the balance of my time describing our treatment activities with adolescents and youths. Generically, we provide subacute detoxification services in free-standing community based intermediate care facilities for individuals who need to be detoxified but does not require this to take place in an acute general hospital. The individual is evaluated by emergency room personnel and then referred to the affiliated intermediate care facility with a length of stay from 14 to 28 days. Halfway House care is for the individual who does not have a home or a stable living situation and also need a protective environment while seeking gainful employment. The length of stay is between 3 and 4 months. Long term care is available for individuals who are chronic alcoholics, who have severe psychological or neurological problems associated with long term alcoholism with a length of stay which is indefinite. All of these facilities are strategically located throughout the state to insure accessibility. We provide outpatient service in each of the 23 counties and Baltimore City. Until this fiscal year we were seeing young people on an out-patient basis with a few referred to adult intermediate care facility and in halfway houses on a special arrangement.

Currently we have identified 2,000 young persons, who have been referred by the Juvenile Services Administration with chemical dependency problems. We have determined that some 200 of those could very readily benefit from residential care. To meet their need we are developing the following services in the system.

The Alcoholism Control Administration, through grants to the County Health Departments, grants to public and private residential programs and cooperative agreements with Juvenile Services Administration will be developing a comprehensive system of intervention and treatment services to chemical abusing adolescents and their families.

The ACA will fund intervention servises for alcohol and chemical abusing adolescents. These services are:

OUTPATIENT TREATMENT

Alcoholism Control Administration has funded adolescent assessment units in twenty separate jurisdictions. These assessment units are designed to provide assessment for adolescents referred from community agencies, who may have an alcohol or other chemical dependence problem. Referrals, most likely, will come from Juvenile Services, Department of Education and Department of Social Services. These adolescent units will also provide outpatient counseling, family counseling, and aftercare services. These assessment units will also be responsible for the referral to and continued liaison with residential treatment beds for which the Alcoholism Control Administration has contracted.

RESIDENTIAL SERVICES

The Alcoholism Control Administration has contracted to provide residential treatment for adolescent chemical abusers for a period of 45–60 days. The Administration anticipates paying in part or in whole for 120 adolescents in the calendar year 1985. These residential programs are:

1. White Oak, Cambridge, MD.
2. Cove Forge, Williamsburg, PA.

3. Massie Unit Adolescent Program, Cumberland, MD.[1]

These facilities will be the first exclusive adolescent treatment programs for chemical dependence in the State of Maryland. Until they become operational in early Spring, 1985, the Alcoholism Control Administration will purchase bed care for adolescent alcoholics in Warwick's Companion Program in Williamsburg, Pennsylvania. We will purchase care for about 50 individuals through June 30th and approximately 120 individuals in FY 85–86. These facilities will accept referrals under our contract only from the approved Assessment Units in the local jurisdictions. This will assure the best selection of candidates. This will also assure that the adolescent and his family will participate in a comprehensive treatment approach in his/her home community following discharge from the residential facility.

Additional staff will be provided to 19 jurisdictions this fiscal year. The other five jurisdictions either already have adolescent programs or are not able to absorb additional staff at this time. Our goal is to have Adolescent Assessment and Treatment Units in 20 jurisdictions by June 30th.

ADOLESCENT ASSESSMENT AND OUTPATIENT SERVICES

Each of these Assessment Units is required to meet certain criteria. (That criteria is attached) in order to secure additional positions we have awarded and to utilize residential beds we have contracted for.

These Units are expected to provide services for Chemically Dependent Youth in which alcohol abuse is present. Very few adolescents are solely alcoholic or alcohol abusers. This will allow the local programs to provide assessment for drug abusing clients also.

ADOLESCENT OUTPATIENT TREATMENT CRITERIA

I. Assessment:

A. Location; B. Individual responsible for provision of assessment.

II. Referral Agreements:

Develop a written referral agreement with JSA and Department of Education indicating the adolescent assessment unit of the Health Department will be recognized as a point of referral for adolescents in need of treatment for alcohol problems.

III. Adolescent Treatment Protocol:

Please submit a treatment protocol for adolescents and their families. This will be for outpatient services.

IV. Rehabilitation Program for Family:

Develop a protocol for treatment/education rehabilitation program for parents of adolescents in treatment, either in the community or in residential care.

V. Aftercare Program:

Please describe the aftercare services to be provided to adolescents who have been referred to residential treatment resources.

ALCOHOLISM CONTROL ADMINISTRATION

Alcoholism is one of the nation's three most serious health problems, along with cancer and heart disease. In this country, problem drinking is estimated to affect approximately 11 million people and the lives of another 44 million family members and friends of people who abuse alcoholic beverages.

The goal of the Alcoholism Control Administration is to establish a comprehensive system of services aimed at the prevention of alcoholism and alcohol-related problems and to provide treatment and rehabilitation services for those persons suffering from the effects of alcoholism or alcohol abuse. To this effort, the Alcoholism Control Administration, which is charged with the responsibility of providing quality treatment services to alcoholic persons, awarded $11,248,177 in FY 1984 to some 106 community-based alcoholism programs, including, thirty-six outpatient programs, thirty-one residential treatment and rehabilitative programs, and thirty-nine prevention projects.

Based upon the Client Oriented Data Profile (CODAP) Management Information System, state-funded alcoholism programs reported the admission of 24,830 clients with a primary diagnosis of alcoholism in FY 1984. The distribution of admissions by treatment modality is presented below:

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[1] Tentative.

ADMISSIONS BY TYPE OF TREATMENT MODALITY, FISCAL YEAR 1984

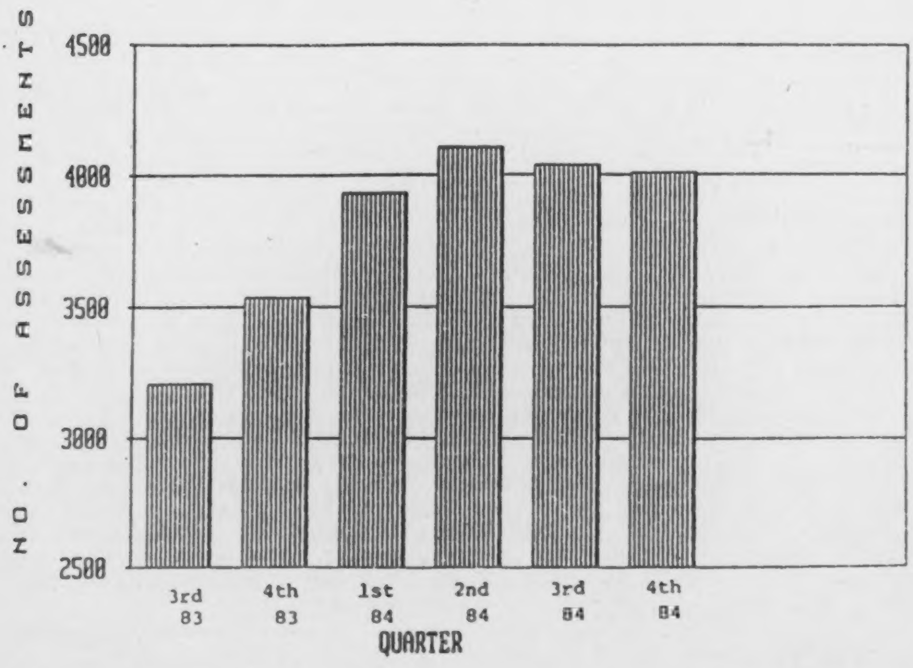
Treatment modality	Total number admissions	Percentage of Admissions
Health department outpatient	14,029	56.5
Hospital outpatient	1,770	7.1
Resident outpatient	442	1.8
Other outpatient	294	1.2
Intermediate [ICF-C/D]	4,151	16.7
Halfway house	961	3.9
Long term	820	3.3
Nonhospital detoxification	1,867	7.5
Other	496	2.0
Total	24,830	100.0

In fiscal year 1984, 16,108 Driving While Intoxicated (DWI) clients were assessed and 72% were referred to local health departments. More than half of the DWI clients assessed were under thirty-five years of age, and more than 10% were under twenty-one. There were few (1%) clients over sixty-five years of age. Most (33%) were male and 82% were white. Below is a graph of the number of DWI assessments from the third quarter of FY 1983 to the last quarter of FY 1984.

Figure 14

DWI ASSESSMENTS BY QUARTER: 1983-84

(Fiscal Years)



Effective December 3, 1984, the administrative and grants management functions for the Alcoholism Control and Drug Abuse Administrations were merged into one unit (Fiscal and Administrative Support) under the Alcoholism Control Administration. This merger represents the final streamlining of administrative activities to enhance the fiscal and program capability of both administrations, and it provides management with improved budgetary and fiscal management support. The newly merged Grants and Contracts Management unit has also established grants review protocols that will include greater senior staff participation; written reports by committee members; and the use of statistical data to evaluate program performance, utilization, and funding allocations.

On the Eastern Shore, the Willis Hudson Center has been given increased funding in order that its program can provide much needed subacute detoxification services. The sixteen bed Coulbourn Center in Somerset County has been opened to provide long-term rehabilitative treatment services for the entire Eastern Shore. In addition, several general hospitals on the Eastern Shore have expanded their alcoholism detoxification capacity.

Treatment services for adolescents are a major priority for the Administration in fiscal year 1985. Adolescent assessment and outpatient units will be developed in the fifteen largest jurisdictions, and adolescent alcohol education projects will be established in all twenty-four jurisdictions. Adolescent projects will be structured short-term programs, supported by client fees and designed as an intervention activity for adolescents referred by the Juvenile Services Administration for drinking offenses. The Alcoholism Control Administration has selected two contractors, one private and one public, from which it will purchase adolescent residential treatment beds. The contracted facilities are the Massie Unit and Warwick, Incorporated. It is estimated that 2,000 adolescents and their families will receive residential and outpatient treatment services in fiscal year 1985.

The Administration has developed three new program initiatives to address the needs of special at-risk populations, including children and youth, women, and the elderly. Additional funding is being requested from the Legislature this year to enhance peer group and youth leadership activities through the addition of prevention workshops and seminars, the development of more treatment-oriented programming for the elderly, and the establishment of two halfway house facilities specifically for female alcoholics.

Funding has also been continued for the third year of the grant to the American Council on Alcoholism, providing four regional consultants to promote the development of new employee assistance programs [EAPs]. In addition, funds have been provided to the AFL–CIO Appalachian Council to encourage more cooperation between labor unions and management in the development of state-wide EAP programs. Studies which focused primarily on absenteeism and illness costs have convinced industry that EAPs may provide an inexpensive strategy for reducing the effect that excessive alcohol use has on job productivity.

The Alcoholism Control Administration is continuing funding of the Comprehensive DWI Program state-wide. In jurisdictions that demonstrated a need for additional resources to eliminate waiting lists for assessment or a need for increased treatment capacities, additional funds were allocated to meet these needs. Local health departments have reduced the number of clients waiting for assessment, even though there has been a substantial increase in the number of DWI arrests. Since 1981 there has been a 42 percent increase in the number of persons arrested in the State of Maryland for drinking and driving. In 1981, 23,651 persons were arrested, with over 34,000 arrests occurring in 1984. The average number of monthly assessments by local health departments was 1,342 in 1984. This is an increase of 19% over the average number assessed in 1983.

In fiscal year 1984, the prevention unit funded forty-one alcohol- and drug-abuse prevention projects. Through these prevention grants, an estimated 30,000 children, adolescents, and adults received community-based educational and informational services on alcohol- and drug-related issues. By fiscal year 1985, every jurisdiction will have either developed and/or implemented an Alcohol and Drug Abuse Comprehensive Prevention Plan. In addition, the Division has contracted with the SMART (Self Management and Resistance Training) Program, a national adolescent alcohol prevention initiative model, to reduce the onset of drinking behaviors. Special initiatives are also being planned for at-risk populations, e.g., pregnant women, Native Americans, and hispanic youth. Through these prevention efforts, prevention services have increased by 20 percent over the previous fiscal year.

House of Representatives,
Select Committee on Children, Youth, and Families,
Washington, DC, April 3, 1985.

Mr. John Bland,
Director, Alcoholism Control Administration,
Baltimore, MD.

Dear Mr. Bland. This is to express our personal appreciation for your appearance before the Select Committee on Children, Youth, and Families at our hearing, "Alcohol Abuse and Its Implications for Families," held here in Washington March 18. Your participation contributed greatly toward making the hearing a success.

The Committee is now in the process of preparing the transcript of the hearing for publication. It would be helpful if your would go over the enclosed copy of your testimony to make sure that it is accurate, and return it to us within three days with any necessary corrections.

Also, we would greatly appreciate your answering the following for the record:

1. What are the costs of the various levels of services for youth in the treatment continuum and who pays for them?
2. In what ways does your agency and its affiliated county programs actively work with schools, youth-serving and other community groups to identify and serve young people before the problems start or become severe?

Let us again express our thanks, and that of the other members of the Select Committee for your testimony.

Sincerely,

George Miller,
Chairman, Select Committee on Children, Youth, and Families.

William Lehman,
Chairman, Task Force on Prevention Strategies.

Lindy (Mrs. Hale) Boggs,
Chairman, Task Force on Crisis Intervention.

State of Maryland,
Department of Health and Mental Hygiene,
Baltimore, MD, April 10, 1985.

Hon. George Miller,
Chairperson, Select Committee on Children, Youth, and Families, House Office Building, Annex 2, Washington, DC.

Dear Congressman Miller.

This is in response to your letter dated April 3, 1985. The cost for the various levels of treatment are as follows:

1. Outpatient treatment unit of service is provided through individual and or group counseling session. We project the unit cost at $10.00.
2. Residential treatment unit of service is a twenty four hour day. We project the unit cost at $100.00.

For fiscal year 1986 we project treating 120 youngsters at an average length of stay of 45 days and a purchase of service amount of $540,000.00 for residential care. Outpatient services we project at approximately $250,000.00 for identification, assessment, referral and treatment. Total cost of services $790,000.00. This amount does not include those families with medical coverage. It is too soon to project what percent of our referrals will have third party coverage.

The sources of funding is ADM Block funding of approximately $350,000.00 and State General funds of $440,000.00.

The following are brief excerpts illustrating ways the Alcoholism Control Administration work with schools, youth serving and other community groups:

DORCHESTER COUNTY YOUTH SERVICES CENTER ($8,420)

A drug/alcohol prevention program will provide for presentations to 5th graders. Family and community individuals will be included in the support network which continues to receive a private foundation grant to match this prevention funding. A prevention consultant will work with the community and school team during the second part of fiscal year 1985.

TALBOT COUNTY HEALTH DEPARTMENT SMART ($9,997)

Six eighth (8th) grade health educators will provide eleven sessions to *290* kids in two middle schools. This peer resistence model uses skill rehearsal and peer leadership to "say no to alcohol and other negative behaviors."

MONTGOMERY COUNTY CARE CENTER ($3,990)

Plans are to reach 400 teachers, grades 4–6 for training in the effects of self-esteem and peer pressure on alcohol and drug abuse. A combination of didactic and experimental exercises will be utilized to provide opportunities for teachers to experience and apply techniques during the time available.

PRINCE GEORGE'S COUNTY PUBLIC SCHOOL SMART ($9,705)

1400 Seventh graders will receive this model in peer resistence training through eleven sessions. An extensive evaluation project is being conducted at this site for the purposes of testing the approach. This project is held in conjunction with Project Graduation and MADART teams trained in previous years.

AMERICAN INDIAN CENTER ($5,000)

Alcohol and drug awareness sessions and cultural activities are provided by this multi-purpose center for Indian children who are at risk for alcoholism. Contact: Gayner Oxendine.

If there is any additional information needed, please do not hesitate to contact me. Thank you.

Sincerely,

John Bland,
Director, Alcoholism Control Administration.

Enclosures.

State of Maryland,
Department of Health and Mental Hygiene,
Baltimore, MD, March 14, 1985.

Hon. Harry Hughes,
State House,
Annapolis, MD.

Dear Governor Hughes: The statistics related to the problem of alcohol abuse, alcoholism and drug abuse are alarming and tragic. Presently, over 90 percent of Maryland's High School seniors have tried alcohol or other drugs, according to our 1983 Survey of Drug Abuse Among Maryland Adolescents. Nearly 20 percent of our children, 14–17 years old are experiencing serious alcohol problems. Other serious implications of these addiction problems are seen in family dysfunction, school drop out, adolescent suicide and a myriad of youth issues which are emotionally as well as financially costly to out citizens.

Each year the alcohol and drug abuse prevention field identifies April as its focal point for raising the public's awareness of chemical abuse. This year we would like you to proclaim April as Alcohol and Drug Abuse Prevention Month to emphasize our progress towards resolving these problems.

On March 29th and 30th the Department of Health and Mental Hygiene and the State Department of Education will co-sponsor its first alcohol and drug abuse conference. The proclamation has already been submitted. We wish to have the ceremony coincide with the conference. I would like to be included along with Darlind Davis, Assistant Director for Prevention and Mr. Hamilton, Director of the Drug Abuse, Administration in the proclamation ceremony.

Thank you for your interest in this important work.

Sincerely,

John Bland,
Director, Alcoholism Control Administration.

Governor's Proclamation

ALCOHOL AND DRUG ABUSE PREVENTION MONTH APRIL 1985

Whereas, Alcoholism and drug abuse has become the leading cause of youthful social, physical, emotional and familial dysfunction; and

Whereas, The problem of drunk and drugged driving among teenagers is the leading cause of death in that age bracket; and

Whereas, The physical and mental deformity and dysfunction caused by fetal alcohol effect (FAE) is the leading preventable form of mental retardation; and

Whereas, Alcohol and drug abuse prevention is a concern and responsibility of all citizens, community agencies and parents working in partnership; and

Whereas, It is the International Year of the Youth; and is a time to reflect on the needs of young people, the future of Maryland

Whereas, The Department of Health and Mental Hygiene and the Maryland State Department of Education have collaborated in the First Annual Prevention Conference; and

Now, Therefore, I, Harry Hughes, Governor of the State of Maryland, to hereby proclaim April, 1985, as Alcohol and Drug Abuse Prevention Month in the State of Maryland.

Given Under My Hand and the Great Seal of the State of Maryland, in the City of Annapolis, this — day of —, in the Year of Our Lord, One Thousand Nine Hundred Eighty Five.

Chairman **Miller**. Ms. Burns.

STATEMENT OF CAROLYN BURNS, VICE PRESIDENT, PROGRAMS, NATIONAL FEDERATION OF PARENTS FOR DRUG-FREE YOUTH

Ms. **Burns**. Thank you, Mr. Chairman.

Good afternoon, Mr. Chairman, and members of the committee, I am Carolyn Burns, vice president of the National Federation of Parents for Drug-Free Youth. I appreciate the opportunity to testify to you today on behalf of the federation.

NFP is a strong supporter of the family and is, in fact, a grassroots organization started by parents who believe that the responsibility for helping their children grow up drug-free is primarily theirs.

We are principally concerned with prevention, but because so many children are in the position of Bret West from this morning, we have to be concerned with intervention and treatment also.

The National Federation of Parents for Drug-Free Youth provides technical assistance, resource materials, advice, and encouragement to the nearly 9,000 parent groups across this country.

Two of the most exciting things we are currently working on are REACH AMERICA, which stands for "Responsible Educated Adolescents Can Help America (Stop Drugs)." We are starting youth groups across the country that work hand-in-hand with parent groups to create a drug-free environment for young people.

We also have another new project called Project Graduation Celebration. We are working with the National Association of Broadcasters, the National Restaurant Association, the National Auto Dealers Association, the National Soft Drink Bottlers, and the National Florists Association on this project. School and parents are given guidelines on how to have graduation celebrations all over the country for young people where there will be neither alcohol or drugs.

Our primary concern is young people. We recognize you must separate young people and adults when talking about alcohol use. Young people in the process of developing their emotional coping mechanisms and social skills, we find that many adolescents who use drugs—including alcohol—are polydrug users; they don't just use alcohol but they use many other drugs in combination.

Chemical dependency is a disease of the feelings, which affects every family member. For those who use drugs, a line is crossed when self-medication is begun and drugs are used as a way of changing or masking one's feelings.

Chemical dependency is a progressive disease which may take years to develop for an adult. Studies show, however, for a young person, this disease can develop in a matter of only a few months.

Because the disease takes time to develop, oftentimes the changes in the behavioral aspects of the family go unnoticed. Denial is a symptom of this disease and families do not recognize the changes in their behavior. They work very hard to look normal to the outside world. That is where the roles develop that you heard about this morning, the enabling mother, the hero child, the passive adult.

More details on this are included in my written testimony.

I have two children who were users. I got into this in 1978. Up until that time I was very naive, believing that because I loved my children and was the best parent I was capable of being they would not use drugs.

As a family, we went to eight different programs before we found a program that could help us. It was very distressing and very disheartening to me as a mother to try and try to get help for my children and not be able to find it.

One of the things that happened in those days, and I think it is changing, is that many parents and counselors looked at the chemical or alcohol use as a symptom of another problem, a symptom of poor self-esteem or poor family communications.

I am not here to tell you that some other problems didn't exist, but before any of those problems could be worked on, we had to look at the chemical problem, the alcohol problem as the primary problem. And unless my children stopped drinking, we were not able to deal with any of the other problems.

What can you do as government officials? What can our Congress do to help the grassroots effort?

First of all, I would like to encourage you to be careful of the resources you promote. Back when I first started in 1978, much of the material coming out of our government was promoting the organization NORMAL, which is the prodrug lobby in this country. Many of the things our U.S. Government printed were referring us to NORMAL for more information.

We need to give a strong clear nodrug message to our young people. After all, alcohol is not only harmful to their health, but it is illegal.

I also support the 21 drinking age because I believe that young people need time to grow up and mature both physically and emotionally, and we need to give them strong messages from the adult population. We need to be parents, not buddies to our children.

Programs for young people that imply that drinking is OK as long as you don't drive need to be reevaluated. The whole process of talking about drinking and driving has been very helpful, and it surely raised the awareness in our country. However, when we address drunk driving, we are only treating a symptom of the problem.

We need to be treating the drinking, and when we address drunk driving, which is important because a lot of lives are lost that way, but let's go even one step further and make sure those people get the help they need.

Thank you very much.

Chairman MILLER. Well, thank you very much.

[Prepared statement of Carolyn Burns follows:]

PREPARED STATEMENT OF CAROLYN BURNS, VICE PRESIDENT, NATIONAL FEDERATION OF PARENTS FOR DRUG-FREE YOUTH

Mr. Chairman, Members of the Committee, I appreciate the opportunity to testify before you today on behalf of the National Federation of Parents for Drug-Free Youth. NFP is a strong supporter of the family and is, in fact, a grassroots organization started by parents who believe that the responsibility for helping their children grow up drug-free is primarily theirs. We are principally concerned with prevention, but because of the vast numbers of young people who are using drugs (which includes alcohol), we have had to become knowledgeable in both intervention and treatment. The National Federation of Parents for Drug-Free Youth provides technical assistance, resource materials, advice, and encouragement to nearly 9,000 parent groups. The Federation is the national network organization for all concerned individuals who are striving to help America's children grow up drug-free and able to reach their full potential.

Chemical dependency is a disease of the feelings which effects every family member. For those who use drugs, a line is crossed when self-medication is begun and drugs are used as a way to change or mask one's feelings. Chemical dependency is a progressive disease which may take years to develop for an adult. Studies show, however, that a young person who starts to use drugs before his emotional coping mechanisms and social skills are developed may progress from experimentation to dependency in just a few months. Because chemical dependency develops gradually, the changes family members experience in their own personal behavior in order to cope with the behavior of the chemically dependent person in the family is also gradual and not readily discerned by family members. Each family member adopts a role of compulsive behavior in order to help cope with the disruption in the family. These roles tend to perpetuate the problem and set the family up for denial. Rolls family members play may include:

Enabler.—makes excuses for the chemically dependent person—tries to control family situation and takes responsibility for the actions of others;

Hero.—excells; tries hard to give the family something to feel good about;

Passive adult.—hides in work or the newspaper—finds the problem too painful to deal with so removes him/herself from it;

Mascot.—defuses explosive situations by focusing attention on himself—manages through humor to ease tense moments;

Lost child.—is a loner—retreats from conflict;

Scape-goat.—frequently the chemically-dependent child—seeks negative attention.

Family members learn to conceal what happens in the family from outsiders as well as close relatives. Feelings are buried and not talked about. Hiding becomes a way of life that goes unchallenged and unquestioned as the lives of those who keep the family secret are twisted, knotted, and distorted.

Treatment approaches which involve the whole family are essential unless there is no other option. All family members need to understand the role they play in perpetuating this family disease. Healthy family members may choose to play any of the roles we have discussed—the difference is that they now make a conscious choice when they will play a particular role and they are not stuck in one role. Healthy families can talk about their feelings and accept that feelings are neither right or wrong. Healthy families can be real and don't have to hide and pretend. These skills are best learned in a treatment setting that includes parents and all children in the family and has a support group for the chemically dependent person, parents, spouse, and all siblings.

Family members can be a tremendous support to the chemically dependent person, both during and after treatment. It is by participating in the treatment process they begin to understand the disease of chemical dependency, the role they have played in perpetuating the disease, how to identify and talk about feelings, and how they can make changes that will help to restore the family to healthy roles. When a chemically dependent person who is drug-free and has been through treatment comes home and the family has had no therapy and are still stuck in their previous roles, it will be much more difficult for the person in treatment to remain drug-free.

There are both long-term and short-term treatments for adolescents. Short-terms are generally 28 days to 6 weeks, while long-terms may last from 6 months to two years. This treatment can be either residential or non-residential, with some of the more progressive programs using a combination of both, dependent on the young person's progress. Treatment modalities vary from the less-intense educational approaches to the highly disciplined approach using peer pressure. For most adolescents, I believe a long-term program using positive peer pressure with a treatment modality that uses rational behavior therapy along with the steps and slogans of Alcoholic's Anonymous as tools for personal change and that involves every family member has the greatest chance of success.

For a large percentage of young people, intervention by family members is what motivates them to treatment, many even before they actually recognize their behavior as a drug-related problem. Short-term programs may be appropriate for a youngster who is strongly motivated to change. We must remember that once the child is straight, he needs to steer clear of his old drug-using friends. The need to belong is very strong for an adolescent and young people who have been to short-term treatment programs find it very hard to break those old peer group ties once at home again. The family also needs time to learn to communicate differently. The maturation process for young people involved with drugs has stopped. Eighteen year olds may have the maturity of a fourteen year old if that's when drug use started. It takes time for these youngsters to grow up.

It is usually a year or more before family members of a young person who is using drugs are aware of the child's drug use. Then, most often, there is a further period of denial by both the family and child that any of the behavior problems the family sees are drug-related. This may sometimes be prolonged by treatment professionals who see drug use as only the symptom of a greater problem. Between December, 1978, and July 4, 1981, when I placed my own son in treatment, we went to eight different programs and counselors. Finally, I knew we must find help that addressed his drug use as the primary problem. Yes, there were other issues to deal with, but first the use of drugs must stop. Once the child is thinking clearly, other problems can be addressed. Learning to identify and talk about feelings is of primary importance for all family members. Through rap sessions, individual therapy, and family counseling, members of the family clear up old grievances and start on the road to wellness. Other family members are encouraged to examine their own drug use and drinking patterns. Families will learn new ways to relate and cope with stress. Personal change and new ways of relating for individual family members will be a support to the family as a unit.

In summary, the most effective way to treat anyone that is chemically dependent is to involve all family members in the treatment process. This is most important for the youthful user since usually he will return to living at home. When all family members understand the reasons for the chaotic situation at home, when they learn to feel and to talk openly again, the cycle of destructive relationships within the family can be broken and family members can be the support system for each other they were intended to be.

National Federation of Parents for Drug-Free Youth,
1820 Franwall Ave., Suite 16 Silver Spring, MD, (301) 649-7100, April 18, 1985.

Hon. Dan Coats,
House of Representatives, Select Committee on Children, Youth, and Families, House Office Building, Annex 2, Washington, DC.

Dear Congressman Coats: I was pleased to be able to testify before the Select Committee on Children, Youth, and Families on March 18, 1985. Thank you for your personal interest and support as a member of Congress in working for drug-free youth.

When I was seeking help for my own sons, as I stated in my testimony, I tried eight counseling and treatment programs before I was able to find a program that helped. The name of that program was Straight, Inc. That program is now located at 5515 Backlick Road in Springfield, Virginia, telephone number 703-642-1980. The following characteristics are characteristics that I was looking for in a drug program that Straight met:

1. Promotes a drug-free lifestyle with drug-free counselors. Recreational drug or alcohol use or mood altering prescription drugs as part of the therapy is unacceptable.
2. It uses the steps of Alcoholics Anonymous.
3. Provides daily support in the form of counseling for at least 6 months. Aftercare continues on a less frequent basis in the form of self-help meetings.

4. At least some of the counselors are recovered abusers who can relate by personal experience and read through the "cons" of their clients.

5. Provides counseling and education for the family. The family learns to recognize and to change its undesirable behavior responses it has developed in response to the abuser's unacceptable behavior. It strives to re-establish good family relationships.

6. It treats drug and alcohol abuse as a disease rather than as a symptom of disease. It believes the unacceptable behavior is caused by the drugs and alcohol rather than by an underlying cause. It makes the abuser responsible for his own actions.

7. The client must learn to live straight in a drug-oriented society, preferably while still in the program. He must change his peer group and leave the drug culture.

Your second question was for suggestions as to how a local community can go about establishing its own treatment and prevention program. Many communities across America have already done this. Usually, it starts through the efforts of one or two caring people. They may be parents, school personnel, law enforcement officials, or legislators. Generally what we look for in a community is that one person who is willing to be a leader. Much can be accomplished through the efforts of a few. The National Federation of Parents has two very helpful kits which tells communities how to organize their efforts. One is "Organizing A Parent Group in Your Community," available for $2; the other is "NFP Parent/Community Task Force Manual," available for $5. I might add that after my husband and I took our sons to Florida, we were so grateful for the help we were given at Straight that we formed a committee of parents who had taken their children to Florida. In seven months, this group raised $345,000 to bring a branch of the Straight Program to Northern Virginia, where it could help families in our area.

Please let me know if you have further questions.

Sincerely yours,

CAROLYN BURNS,
Vice President.

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, DC, April 3, 1985.

Mrs. CAROLINE BURNS,
Vice President, National Federation of Parents for Drug-Free Youth,
Silver Spring, MD.

DEAR MRS. BURNS: This is to express our personal appreciation for your appearance before the Select Committee on Children, Youth, and Families at our hearing, "Alcohol Abuse and Its Implications for Families," held here in Washington March 18. Your participation contributed greatly toward making the hearing a success.

The Committee is now in the process of preparing the transcript of the hearing for publication. It would be helpful if you would go over the enclosed copy of your testimony to make sure that it is accurate, and return it to us within three days with any necessary corrections.

Also, we would greatly appreciate your answering the following for the record:

1. How does the Federation and its members work with parents who themselves have problems which may contribute to the substance abuse problems of their children?

2. Does the Federation work with young people with substance abuse problems who are out of the home? In what ways?

Let us again express our thanks, and that of the other members of the Select Committee for your testimony.

Sincerely,

GEORGE MILLER,
Chairman, Select Committee on Children, Youth, and Families.
WILLIAM LEHMAN,
Chairman, Task Force on Prevention Strategies.
LINDY (Mrs. HALE) BOGGS,
Chairman, Task Force on Crisis Intervention.

NATIONAL FEDERATION OF PARENTS FOR DRUG-FREE YOUTH,
Silver Spring, MD, (301) 649-7100, April 18, 1985.

Hon. GEORGE MILLER,
Chairman, Select Committee on Children, Youth, and Families, House of Representatives, House Office Building, Annex 2, Washington, DC.

DEAR CONGRESSMAN MILLER: Enclosed please find corrected copy of my testimony which was given before the Select Committee on Children, Youth and Families on March 18, 1985.

I would like to answer the additional questions you have asked me as follows:

Question. How does the Federation and its members work with parents who themselves have problems which may contribute to the substance abuse problems of their children?

Answer. The National Federation of Parents for Drug-Free Youth focuses exclusively on adolescent use of drugs and alcohol. We do, however, encourage parents to closely examine their own drugs and alcohol use patterns. We believe that it is imperative for parents to recognize that they serve as role models for their children. We encourage families who have these problems to seek counseling that works with the entire family so that each problem in the family becomes involved in the treatment process and can address individual problems as well as family issues.

Question. Does the Federation work with young people with substance abuse problems who are out of the home? In what ways?

Answer. The National Federation of Parents for Drug-Free Youth is a grassroots parents organization. We network our efforts with various community programs that may be working with children who are out of the home. Many times, there may also be a caring relative who is helping a child no longer living with his/her family. Our main concern is prevention, and we are not a treatment facility. Our new youth program "REACH America" (Responsible, Educated Adolescents Can Help America (stop drugs!)) will enable youngsters through youth groups and school groups to become involved in drug-free activities whether or not they are living with their parents.

Please let me know if you have further questions. I hope to work with you at a future time.

Sincerely yours,

CAROLYN BURNS,
Vice President.

Enclosures.

Chairman MILLER. To all the panels, we thank you.

We have about 2 minutes and 20 seconds. I don't know if you have any questions, Congresswoman Boggs?

Mrs. BOGGS. I am very pleased that Dr. Blume mentioned the fetal difficulties and the infant mortality, of course, which is one of the great problems in this country that this panel has been interested in.

Also, Mr. Bland, I know you do followup services and I would just like to say—because he came over specifically to ask me, would I mention this to the next person who talked about followup programs. But Mr. West said we failed to say that continued attendance at AA or whatever followup program you use is an essential ingredient and the young people keeping away from the peers that were their drinking buddies is also very essential.

Do you agree with that?

Mr. BLAND. Very much so. We keep youngsters in treatment minimally, Congresswoman Boggs, for a year irrespective of what stages they require.

We feel that that is absolutely essential

Mrs. BOGGS. Thank you.

Chairman MILLER. Mr. Coats.

Mr. COATS. Mr. Chairman, I want to thank the witnesses. I am not going to ask questions.

It is probably important for our future potential use of this room we get out of here at 1:45.

Chairman **Miller**. We have a problem with permanency planning since we don't have our own committee room.

I want to thank you very much. As we leave this subject for this day, I think it is important to remember what Dr. Blume said. While there were typical families we heard from, the fact they got treatment is atypical. If the statistics we have about the number needing and those receiving treatment are accurate, you begin to realize that the number who receive successful treatment are a very small portion of the alcoholic population in this country.

We ought not to lose sight of that fact.

Thank you very much.

Mrs. **Boggs**. May I also thank Mr. Daigle and Governor Graham for sharing their extensive research with us. I was totaling it; they have 196 groups we can now go to that are listed in their booklet, and we can get additional help.

Thank you very much.

Chairman **Miller**. Thank you very much.

The committee stands adjourned.

[Whereupon, at 1:45 p.m., the subcommittee adjourned, subject to the call of the Chair.]

OPENING STATEMENT OF CONGRESSMAN THOMAS J. BLILEY, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

HEARING: "ALCOHOL ABUSE AND ITS IMPLICATIONS FOR FAMILIES"

Thank you, Mr. Chairman. I am glad to be back on the committee. I look forward to many accomplishments benefitting our Nation's families.

We begin our hearings this Congress with an issue that statistics reveal is a growing problem affecting approximately one-third of American families. And these numbers are rising. These same statistics tell us that 40% of all problems brought to family court involve alcohol abuse in some way. The necessary care of the alcoholic and the involved family siphons an estimated $49 billion from our economy each year. Spouse abuse and the dissolution of the family unit are but two of the ill effects of alcoholism. These effects do not stop here, however, since the basis of our society lies in the strength of its basic unit, the family.

The alcoholic, the family, friends and co-workers involved, and our Nation as a whole then suffers when alcoholism runs rampant. We must treat this disease at its core, within the alcoholic's family. This morning we will hear that the family approach is endorsed by many and has experienced much success.

Because the problem of alcoholism in the family has only recently come under the public scrutiny that its importance warrants, these hearings are extremely important. By our proper actions, we can help ensure that this problem grows no further.

I want to re-emphasize the importance of these hearings. I urge my colleagues to look at alcoholism as it affects individuals and families, and how to use those family resources to fight alcoholism and strengthen our society. And in so doing, it is vital, of course, to examine healthy families: families without alcohol problems, both drinkers and abstainers, to see how they avoid aclohol-related problems.

Again, Mr. Chairman, let us look at what makes and keeps families healthy.

Thank you.

PREPARED STATEMENT OF CAROL N. WILLIAMS, PH.D., CENTER FOR ALCOHOL STUDIES, BROWN UNIVERSITY, PROVIDENCE, RI

In a Gallup Poll prepared for the 1980 White House Conference on Families, 45 percent of Americans polled felt that family life had deteriorated in the last 15 years. Alcohol abuse was identified by 59 percent as the most harmful influence on family life, and 25 percent stated that their families were personally affected by alcohol problems (a number that went up to 33% in a 1982 Gallup Poll).[1] Yet, because of the stigma of alcoholism and lack of understanding of its dynamics and how it affects the quality of family life, family members often suffer in helpless isolation, afraid to seek help and unaware of the fact that with help families can be brought back to healthy levels of functioning.

A well-functioning family provides a stable social and economic environment in which the spouse, parent, and child roles and responsibilities are clear and appropriate, mutual love and esteem are provided, and needs for dependency and independence are met. In a family with alcoholism the organizing principle is the alcoholism, not the mutual meeting of needs. As the alcoholism progresses and the alcoholic becomes more preoccupied with the drug alcohol, so does the family: acquiring it, hiding it, alternatively attacking or protecting the alcoholic and each other, denying that alcoholism is affecting family life, or minimizing its effects. In a desperate attempt to achieve "normalcy" and stability the family's attention focuses increasingly on the alcoholic behavior, leaving little energy to meet other vital needs of its members.

In the words of one therapist:

In all the time I have spent working with and observing families, I cannot recall a single, openly communicating, mutually respecting, well-oriented, lovingly close family in which an actively participating member had a serious and lasting drug habit—transient experimentation, occasional booze or pot, yes, but disabling and lasting drug use, no.[2]

In order to reduce the impact of alcoholism on the family, the family must be strengthened and supported. Without intervention through professional therapy or self-help groups, the impact on the family has intergenerational repercussions. The children are more likely to marry alcoholics, develop alcoholism, or recreate the same family environment they grew up in, which predisposes the grandchildren to alcoholism.[3]

Too often treatment addresses only the alcoholic. Treatment policy must be formulated that ascribes the alcoholic's family equal importance. Public policy is needed that creates a greater awareness of the needs of the spouse and children in an alcoholic family, educates the public about the familial impact of alcoholism, and makes access to help through school systems, health care systems, and social and community agencies more available. Because the needs of the children are addressed elsewhere, the rest of this paper will focus upon the impact of alcoholism on the two major roles in the family taken by couples: as spouses and as parents.

IMPACT OF ALCOHOLISM ON THE MARITAL DYAD

Ideally, marriage is viewed as a partnership in which two people share responsibilities, meet social, emotional, physical, and financial needs, and provide mutual esteem and support. The effect of excessive drinking on this partnership is to destabilize it emotionally and financially. As the excessive drinker loses control of his or her alcohol use and the negative consequences increase, conflicts around the drinking increase, with corresponding feelings of negative self-esteem, guilt, anger, and isolation for both the partners. Both may begin to minimize, rationalize, and or deny that the drinking is problematic, partly in an attempt to maintain stability in the marital dyad and partly out of lack of knowledge of alternatives and feelings of helplessness.

FINANCES

Financially, the couple is also often stressed. In addition to income loss due to supporting an alcohol habit, alcoholics are also more often underemployed or fail to advance, lose jobs, and have higher absenteeism, illness and accident rates than do nonalcoholics.[4, 5] Even when social economic status is controlled, families of alcoholics have greater financial difficulties than do families without alcoholism.[6, 7]

VIOLENCE

Violence against the spouse, with the wife as the most frequently reported victim, is also associated with alcohol abuse. One review found that alcoholism or excessive drinking was associated with 45 to 60 percent of spouse abuse.[8] A study of records of families involved in a family court, often for divorce-related issues, reported that the most commonly cited problem area was violence, with alcohol-related problems the third most commonly cited.[9] Nearly three-fourths of the alcohol-involved families had problems with violence, whereas less than one third of the non-alcohol-related family cases did.

Research by Frieze and colleagues[10] on battered wives found that the most severe male batterers were also the heaviest drinkers and were most likely to batter their wives when drinking. About a third of the comparison group of married women from the same neighborhood also experienced violence in their marriages, but not as severe as that experienced by the study group. Using factor analysis, three types of marriage were identified. In one, both the husband and wife had alcohol problems, violence between them almost always occurred with the husband was intoxicated, and many of the fights started with disagreements over drinking. The second group of couples would fight when drinking but were not particularly violent. In the third group highly violent interactions occurred between the spouses and to a lesser extent toward the children (which did not occur in the first two groups), but the violence was associated with low impulse control, not alcohol use.

SEPARATIONS AND DIVORCE

Although alcoholics marry at the same rate as the rest of the population, a significantly greater number of these marriages end in separation or divorce, with the rates of divorce being higher for alcoholic women than alcoholic men.[11] Wives of alcoholic men are more likely to stay with their husbands, for economic, emotional, and family needs, whereas husbands of alcoholic women tend either to leave their wives or be problem drinkers with them.

SPOUSE CHARACTERISTICS

It was originally thought that women who married alcoholic men did so for their own neurotic needs, but later research reported that these wives were not more psychologically disturbed than other wives and that their emotional distress developed after they were married and subsequent to their husbands' alcoholism.[12] Steinglass found that the wives' symtomatology was related to the severity of drinking and its perceived consequences when the spouse was drinking.[13] When the spouse was sober the wife's distress and symptoms lessened.

It would appear that women who do have more psychiatric problems and who marry men already showing signs of alcohol abuse during courtship are children of alcoholics.[14] In this instance assortative mating may be occurring in that children of alcoholics and problem drinkers are looking for others with similar family backgrounds and drinking patterns.[15] I would speculate that these women would be the ones most likely to stay in a marriage with an alcoholic for a variety of reasons: the marital dyad modeled in the family of origin is recreated in the family of procreation, the communication styles and family roles are familiar, self-esteem and knowledge of what behavior is normal is already lowered, and children of alcoholics are extremely loyal to and protective of alcoholics.

Less is known about the husbands of alcoholic wives. In general, the wives describe their husbands as domineering, emotionally inaccessible, and rigid.[16] Husbands are more likely to drink with their wives even though they disapprove of their wives' drinking. These husbands also tend to have alcohol problems. One 12 year longitudinal study of alcoholic women's marriages found that 50% of their husbands were alcoholic and 14% had psychiatric disorders.[17] The women's alcohol problems began after their marriage and most of those who reported no marital discord and sympathetic husbands were married to alcoholics.

In terms of treatment interventions for alcoholic couples, McCrady found that a combination of treatment for alcoholism and marital therapy produced the consistently best outcomes in terms of sobriety and marital satisfaction.[18]

Patients were randomly assigned to one of three treatments: sobriety counseling with the spouse sitting in on the sessions; sobriety counseling with the spouse focused on helping keep the alcoholic sober; and sobriety counseling with marital therapy counseling. Although all had positive drinking outcomes at the end of the 18 month follow-up, the first treatment resulted in stable sobriety but low marital satisfaction and the second in less stable sobriety rates and lower marital satisfaction during the 18 month followup. The implications for treatment are that couples need help both in achieving sobriety and in rebuilding their relationships to maintain a healthy satisfactorily functioning marriage.

EFFECT OF ALCOHOLISM ON PARENTING SKILLS

The effect of alcoholism on a couple's ability to parent is an extremely important but neglected area of study. In child development theory, factors crucial to the development of competent, well-adjusted children and adults are positive parent-child relationships, stability of home life, the meeting of physical needs, consistent methods of reward and discipline, and feelings of trust and security. In alcoholic families, however, parents become so absorbed with the difficulties being caused by the drinking, they abdicate parental authority and responsibility and are unable to maintain a stable home emotionally, financially, or maritally, to their own distress and that of the children.

QUALITY OF PARENT-CHILD RELATIONSHIP

The disruption of the parent-child bond in alcoholic families is mentioned with painful frequency in the alcoholism literature. When children are interviewed, they don't cite drinking as the cause of their distress as much as the parental quarreling and inconsistency, and their feelings of being rejected, unloved, unwanted, and emotionally neglected by their parents.[6,19] They felt distant and alienated from, as well as rejecting of and angry toward both the alcoholic *and* the nonalcoholic spouse. Children were resentful at having to take on parental responsibilities in the family.

Krauthamer found that alcoholic mothers displayed more ambivalent, confused, and inconsistent attitudes toward their children than did nonalcoholic mothers, regardless of class.[20] Mothers were alternately rejecting of an overprotective of their children and the children were described as cold, distrustful, and more dependent that control children. However, Krauthamer concluded that the mothers' attitudes and behavior were more a result of the drinking than of personality disorders and were reversible with sobriety. In a study of 116 alcoholic mothers Corrigan[21] reported that 56% of the mothers felt that the quality of their mothering and relationships with their children had suffered. Parents are not unaware of the effect of their drinking on their children. Over 50% of the parents in a child care study of alcoholic and opiate-addicted parents by Black and Mayerth[22] and 75% of the alcoholic women in the Corrigan study expressed genuine concern about the interference of the drinking with their ability to parent.

Whether recovery improves the parent-child relationship is not certain. In one study teenage children of recovered alcoholics reported feeling better about themselves and their parents than did teenagers of unrecovered alcoholics.[23] However, Booz-Allen and Hamilton[6] reported no relationship between recovery in the parent and a lessening of problems their adult children faced, and Black[24] stated from clinical experience that it takes years for parents to become healthy role models. This process could probably be hastened through the teaching of effective parenting skills. Otherwise, this disruption lasts a lifetime.

Several studies have indicated that older chronic alcoholics were living in more debilitated conditions with little or no family support and more negative family attitudes toward them than were nonalcoholic elderly. Baer, Morin, and Gaitz[25] reported that families of Organic Brain Syndrome patients were much more likely to be accepting and sustaining of their parents and to follow through on treatment recommendations and use of community resources than were families of alcoholics.

STABILITY OF HOME LIFE

Parents are often unable to provide a secure home life for children in alcoholic families. In addition to the greater financial distress and higher rates of divorce and violence among alcoholic couples addressed in the previous section, family life was also disrupted by parental separations, illnesses, arrests and incarceration, and drinking sprees.[26] Children were often raised by others for long periods of time, either through interventions by extended families or public institutions, or else separated themselves from their parents. In one national study, runaways were four times more likely to have intoxicated mothers and 15 times more likely to have intoxicated fathers than was a comparison group of nonrunaways.[27] In another type of stability study, families in which important rituals such as dinners, holidays, and celebrations were disrupted by parental drinking had a greater likelihood of transmitting alcoholism to the children, whereas families able to protect their rituals from disruption by drinking were less likely to transmit alcoholism.[28]

ADEQUACY OF CHILD CARE

In one of the few studies of the adequacy of child care in alcoholic families, Williams compared three groups of parents: fathers with no alcoholic spouse; mothers with no alcoholic spouse; and parents who were both alcoholic.[29] Children in families with two alcoholic parents experienced the greatest incidence of both abuse and neglect, received the most inconsistent discipline (they were both hit and hugged more), spent the least amount of time with their parents and were least wanted at birth of the three groups. These parents were also significantly younger yet had approximately the same number of alcoholism treatments and more arrests and psychiatric problems than the other two groups of parents.

Children in the alcoholic mothers group were likely to be neglected but not abused. These mothers had the least family stability; they had the lowest income and job skills of the three groups and three-fourths of them were separated single parents. Their childcare practices and positive regard for their children were lower than that of the alcoholic fathers group but higher than the two alcoholic couples group. Children in the alcoholic fathers group received the most adequate childcare and had the most stable family life and positive regard of the three groups. However, all of the fathers were married and the spouse had primary responsibility for childcare, which probably mitigated the impact of the alcoholism. In comparison to families without alcoholism, none of these families were functioning well. No differences in childcare were evident by race of parent or sex and age of child.

Children from alcoholic families are also more likely to experience illnesses and injuries than are children from nonalcoholic homes. [30-32] This is probably a combination of factors. One is that the child may be less well supervised and cared for by the alcoholic parent and spouse, leading to a greater occurence of illness and injury through neglect and sometimes abuse. The second is that children in alcoholic families are under greater stress and have more psychosomatic health problems as a result. Either way the indication is that parents are having a difficult time providing a psychologically and physically healthy environment for children to grow in.

The similarities between the childhood experiences of alcoholics and of those of their current children is striking. Both describe almost verbatim the same distress over the disruptions in the parent-child relationship, separations and lack of family stability, and inadequacy of child care.[33] Given that children of alcoholics have a greater probability of marrying an alcoholic or becoming one, it would also follow that they would recreate in their families of procreation the dynamics and inadequate parenting skills acquired in their families of origin. Just as the alcoholic needs to learn to stay sober, alcoholics and their spouses need to learn to parent. Such skills can be taught through programs such as Parent Effectiveness Training,[34] which can help greatly to clarify roles, expectations, responsibilities, and communication in a family system. Too often the need for this vital skill is overlooked in alcoholism counseling programs.

IMPLICATIONS

Alcoholism has a negative impact on the two major roles adults acquire in a family: spouse and parent. In both relationships, the focus of attention is on the drinking behavior and its consequences to the detriment of the fulfilling of other vital needs of family members. Roles, expectations, responsibilities, and lines of communication become blurred, and rigid, highly patterned interactions among the family members develop in an attempt to achieve stability. Without adequate role modeling and alternatives, these models for marital dyads and parenting are recreated intergenerationally, so that even if the children do not themselves become alcoholic, they create family climates that enhance the possibility of third generation alcohol problems.

With intervention this cycle can be disrupted. The spouse and children are as in need of marital and family counseling as the alcoholic is in need of sobriety counseling. Relationship, parenting, and communication skills can be taught. Greater awareness of these issues is needed among policy and treatment people if the whole family is to be made healthy. Insurance coverage should be available for these families. It has been shown that in the short term the costs of medical care for alcoholics and those with other disorders could be reduced through intervention now.

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